National Library of Canada
Acquisitions and Bibliographic Services Branch
395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale du Canada
Direction des acquisitions et des services bibliographiques
395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file Votre référence

Our file Notre référence

NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

Canada

University of Alberta

The Nonurgent Patient in the Emergency Department

by

Carla Policicchio

A THESIS SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
AND RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF NURSING.

FACULTY OF NURSING

EDMONTON, ALBERTA
FALL 1993

National Library of Canada
Acquisitions and Bibliographic Services Branch
395 Wellington Street
Ottawa, Ontario
K1A 0N4

Bibliothèque nationale du Canada
Direction des acquisitions et des services bibliographiques
395, rue Wellington
Ottawa (Ontario)
K1A 0N4

Your file *Votre référence*

Our file *Notre référence*

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-88245-X

Canada

UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR: Carla Ann Policicchio

TITLE OF THESIS: The Nonurgent Patient in the Emergency Department

DEGREE: Master of Nursing

YEAR THIS DEGREE GRANTED: 1993

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves all other publication and other rights in association with the copyright in the thesis, and except as hereinbefore provided neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

Carla Ann Policicchio
4712 Whitemud Road
Edmonton, Alberta
T6H 5M3

DATE: Aug 13/93

UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled THE NONURGENT PATIENT IN THE EMERGENCY DEPARTMENT submitted by CARLA ANN POLICICCHIO in partial fulfillment of the requirements for the degree of MASTER OF NURSING.

Marion Allen

Dr. Marion Allen (Supervisor)

Peggy Anne Field

Dr. Peggy Anne Field

Myer Horowitz

Dr. Myer Horowitz

DATE: Aug 13. 1993

ABSTRACT

A subtle, but consistent change in the utilization of Emergency Departments has occurred over the last thirty years. An increase in the number of patients with nonurgent conditions coming to Emergency Departments for medical care has been documented in the literature. Research has not been conducted, however, on the effects of the changes in Emergency Department utilization on the nonurgent patient or on the decision-making process patients use to access health care. There is not a clear understanding of why nonurgent patients choose to utilize an Emergency Department. The purpose of this study was to answer the question, "What is it like to be a nonurgent patient in Emergency?".

A descriptive, interpretive ethnographic type design was utilized to facilitate understanding of the meaning individuals ascribed to the experience of coming to an Emergency Department. A purposeful selection of nine nonurgent patients was utilized to ensure the representativeness of the population. Two family members, four Emergency nurses, and two Emergency physicians, as well as four urgent patients were included in the study as secondary informants. One or two semi-structured interviews, lasting one to two hours were conducted. Interviews were taped and later transcribed for analysis. The process of data analysis was conducted simultaneously with that of data collection. Three level coding and constant comparative analysis were utilized to clarify emerging themes.

The study of the experience of the nonurgent patient in Emergency facilitated the development of a decision-making model. The model, used by nonurgent patients, identifies the process by which these individuals assess their illness or health concern and chose the option to visit a specific Emergency Department. An explicit part of the model is the factors which are influential in determining the appropriate health care service. Following a descriptive interpretation of this process, a comparison was done to establish how the experiences of nonurgent patients related to those of urgent patients. As the

environment of the Emergency Room and the Emergency staff influence the experiences of nonurgent patients, these were also discussed.

The clinical significance and applicability of this study facilitates the development of more effective strategies to care for nonurgent patients in the Emergency Department. The findings of the study has implications which extend to all areas of nursing practice: clinical, education, administration, and research. Implications in each of these areas were addressed.

DEDICATION

To my husband Sett for his constant positive support and encouragement in my thesis, as well as all my endeavors.

To my daughters, Angela and Vanessa, for their love and understanding.

ACKNOWLEDGEMENTS

I wish to acknowledge the contribution of Dr. Marion Allen, Thesis Supervisor, for her expertise, encouragement and valuable guidance.

I also wish to acknowledge Dr. P. A. Field and Dr. M Horowitz for their expertise and assistance.

I would like to thank the Alberta Foundation for Nursing Research for their financial support.

Finally, I wish to express my sincere thanks to the patients, their family members, and the Emergency Department staff, whose participation made this study possible.

TABLE OF CONTENTS

CHAPTER **PAGE**

I. INTRODUCTION **1**

Purpose 2

Research Problem 2

Definition of Terms 3

Significance Of Study 3

II. REVIEW OF THE LITERATURE **5**

Emergency Department Utilization 5

Causes Of Increased Emergency Department Utilization 6

The Nonurgent Patient 12

Result Of Changing Utilization Patterns Of Emergency Departments 15

III. METHODS **22**

Design 22

Informant Selection 23

Access To Sample 25

Data Collection 26

Data Analysis 28

Reliability And Validity 31

Ethical Considerations 34

IV. FINDINGS **37**

Description Of Primary Informants 37

The Nonurgent Patient 38

CHAPTER PAGE

Reasons For Coming To Emergency 38

The Experience Of The Nonurgent Patient 42

Assessment Of The Problem 44

Knowledge Of Resources 45

Selection Of Health Care Service 45

Family Physician 45

Medi-Centres 48

Emergency Department 51

Past Experiences 56

Choice Of Hospital 63

The Setting 67

The Physical Environment 68

Nursing Organization Of The Emergency Department 71

Patient Flow 75

Expectations 76

Expectations Of Care In The Emergency Department 77

The Visit Of The Nonurgent Patient 87

The Urgent Patient's Experience In The Emergency Department 92

Reasons For Coming and the Decision-Making Process 92

Knowledge Of Resources 95

Selection Of Health Care Service 95

Family Physician 96

Medi-Centres 101

Emergency Department 103

Past Experiences 105

CHAPTER PAGE

Choice Of Hospital....108

Expectations....109

The Visit Of The Urgent Patient....115

The Visit....121

Staff's Perception Of The Visit To The Emergency Department....121

Utilization Of The Emergency Department....122

Emergency Staff's Perception Of The Nonurgent Patient....125

Impact Of Nonurgent Patients On The Emergency Department....142

V. DISCUSSION OF FINDINGS....154

Implications....166

Clinical....167

Education....168

Administration....168

Research....169

Reflections On Research Methods....171

REFERENCE LIST....172

APPENDIX A: Patient Information Letter....182

APPENDIX B: Family/Friends Of Patient Research Information Letter....185

APPENDIX C: Urgent Patient Information Letter....188

APPENDIX D: Emergency Department Staff Research Information Letter....191

APPENDIX E: Informant Demographic Data....194

APPENDIX F: Nonurgent Patient Consent Form....196

CHAPTER PAGE

APPENDIX G: Family/Friends Consent Form 199

APPENDIX H: Urgent Patient Consent Form 202

APPENDIX I: Emergency Department Staff Consent Form 205

LIST OF FIGURES

FIGURE **PAGE**

4.1 Decision-making Model of Patients.....43

4.2 Nursing Organization of the Emergency Department.....73

Chapter 1

Introduction

Traditionally the role of the Emergency Department has been for the care of urgent medical needs (Stratmann & Ullman, 1975) and has represented a source of health care to individuals who are acutely or critically ill. However, a subtle, but consistent transition in the utilization of Emergency Departments by patients who are not seriously ill, as defined by professional health care workers has occurred over the past thirty years (Davidson, 1978; Yoder & Jones, 1981). Individuals seeking medical attention have begun increasingly to utilize the services provided within an Emergency setting, as a convenient, quick alternative to health care for nonurgent conditions. It was anticipated with the advent of Medi-Centres, that a large proportion of the nonurgent patients using Emergency Departments would subsequently view such a centre as a viable alternative for health care. Although hospital Emergency Departments statistically did see a reduction in the numbers of nonurgent patients coming to their facilities, there remains a large percentage of nonurgent patients who continue to seek health care within an Emergency setting.

Nurses who elect to work in Emergency Departments, as well as physicians, do so with the belief that they will subsequently be working in a critical care area, caring for acute and critically ill patients. The drastic increase in nonurgent visits has resulted in the overcrowding of Emergency facilities and heavy staff workloads (Vaughan & Gamester, 1966). With the increased number of acutely ill patients coming to Emergency, as well as the large volume of nonurgent patients, Emergency staff have progressively begun to feel frustrated with the increasing demands placed on them. This sense of frustration is heightened by the Emergency staff feeling as though the nonurgent patients are taking

valuable time away from what the staff believe to be their primary responsibility, the care of the acute and critically ill or injured.

As a result of the changing pattern of utilization by nonurgent patients, open conflict between staff and nonurgent patients has developed (Yoder & Jones, 1981). The legitimacy of the illnesses of nonurgent patients as well as their decision to seek medical care within the setting of the Emergency Department is often in question. The consequences of the change in the utilization of Emergency Departments by nonurgent patients has had an impact on the functioning of existing facilities and possibly the care of all patients, in particular, the care of nonurgent patients.

Purpose

The impact on Emergency Departments of the changing patterns of utilization by nonurgent patients has been documented by research. This research has included the examination of the characteristics of nonurgent patients, and the effects of the drastic increase in nonurgent patients on Emergency Departments. Research has not been conducted, however, on the effects of the changes in Emergency Department utilization on the nonurgent patient or on the decision-making process patients use to access health care. There is not a clear understanding of why nonurgent patients choose to utilize an Emergency Department.

Research Problem

It is vital that nurses adapt to the changing role of the Emergency Department and the needs of nonurgent patients (Stratmann & Ullman, 1975; Toohey, 1984) through greater understanding of the experience of being a nonurgent patient, within the context of

individuals' frames of reference. It is hoped that a description of this experience from the nonurgent patients' perspective will facilitate the development of concepts which enhance the understanding of human behavior, and contribute to nursing practice through the development of nursing knowledge. Therefore, the purpose of this study was to answer the question, "What is it like to be a nonurgent patient in Emergency?".

Definition of Terms

Emergent: Life- or limb-threatening illness; condition requiring immediate medical attention, a chronic illness which has suddenly become acute.

Urgent: A condition which must be treated within a period of a few hours to decrease the possible risk of further injury or increased severity of illness; disorder is acute but not life-threatening.

Nonurgent: A condition which is minor in severity or nonacute and can wait twenty-four hours to be treated; condition not requiring the resources of an emergency service (Lavenhar, Ratner, & Weinerman, 1968).

Significance of the Study

The heightened concern regarding changing utilization pattern in the Emergency Department has been demonstrated by the research conducted to investigate the effect of this transition. The focus to date has centered on the impact of this change on existing

Emergency Departments, the demographics of nonurgent patients, as well as the effect on health care providers. Research has not been conducted to examine the effect of this change in utilization on the nonurgent patient. In order to evaluate the nursing care of nonurgent patients, it is essential that nursing clinicians gain insight into the process of how nonurgent patients choose the appropriate sources for medical care, and the "subjective experiences" (Artinian, 1988, p. 138) of the care provided.

The beliefs and values of consumers of health care are critical elements in the development of nursing knowledge, and ultimately improvement in quality of care. The clinical significance or applicability of this study is associated with the belief that through a greater understanding of the meaning patients ascribe to their experiences, practicing nurses will gain insight into what it is like being a nonurgent patient in Emergency. The implications of this knowledge may assist nurses in the clinical area to develop more effective strategies to care for such patients in the Emergency Department (Diers, cited in Leininger, 1985), and ultimately increase the patients' satisfaction of their care, and promote a more conducive environment. If greater insight into nonurgent patients is gained, nurses working within the Emergency Department may be less frustrated with the evolving change in utilization, thereby increasing the ability to cope with, and adapt to, these changes in utilization (Morse, 1989). The clinical relevance of this study is directed towards the examination of a clinical problem which has implications for both consumers and providers of care.

Chapter 2

Review of the Literature

Literature presented in this review originated from medical, nursing, sociological, psychological, anthropological, and administrative health care sources. This review will progress from a discussion of Emergency Department utilization, to the research conducted examining the nonurgent patient and the effects of the drastic increase in nonurgent patients on Emergency Departments.

Emergency Department Utilization

Since the late 1950s, a subtle, but consistent change in the utilization of Emergency Departments by patients who are not seriously ill, as defined by professional health care workers, has occurred (Yoder & Jones, 1981; Davidson, 1978). Traditionally, the role of the Emergency room has been for the care of urgent medical needs (Stratmann & Ullman, 1975), however, there is increased use of Emergency Departments by nonurgent patients (Stratmann & Ullman, 1975; Vaughan & Gamester, 1966; Gibson, 1973; Jacoby & Jones, 1982; Powers, Reichelt, & Jalowiec, 1983). With the evolving change in utilization, the focus in Emergency Departments has shifted from providing Emergency care to the acutely ill, to providing routine primary health care to nonurgent, non-referred patients (Gibson, 1973; Yoder & Jones, 1981). On a national scale, Andreoli and Musser (1985) identified that while approximately 15-20% of the Emergency visits are for urgent problems, approximately 75-80% are for nonurgent concerns. The drastic increase in nonurgent visits has resulted in the overcrowding of Emergency facilities and heavy staff workloads, particularly during weekends, evenings, and holiday periods

(Vaughan & Gamester, 1966). The ultimate result has been one of frustration on the part of patients, as well as that of the nursing staff, and conflict between patients and nurses when care expectations differed (Yoder & Jones, 1981; Powers, Reichelt, & Jalowiec, 1983; LaFargue, 1985).

Causes of Increased Emergency Department Utilization

With the increased use of Emergency Departments by nonurgent patients, research has been conducted to determine causes of increased Emergency Department utilization (Kluge, Wegryn, & Lemley, 1965; Gibson, 1973; Davidson, 1978; Government of Alberta, 1989); consumer attitudes towards Emergency Department utilization (Kirkpatrick & Taubenhaus, 1967; Jacobs, Garrett, & Wersinger, 1971; Stratmann & Ullman, 1975; Wabschall, 1983); and characteristics of patients who utilize Emergency services (Torrens & Yedvab, 1970; Perkoff & Anderson, 1970; Berman & Luck, 1971; Parker, 1982; Powers, Reichelt, & Jalowiec, 1983; Andren & Rosenqvist, 1987).

Explanations for the tremendous expansion of utilization include a lack of accessibility to other sources of health care due to an insufficient number of physicians and /or the unavailability of the patients' family physicians after office hours (Davidson, 1978). The lack of available alternatives to health care because of the unavailability of family physicians was identified as a significant cause of increased use of Emergency Departments by Gibson (1973). Similarly, a trend identified by Kluge, Wegryn, and Lemley (1965) of family physicians referring their patients to Emergency units after office hours further expands the volume of patients in Emergency Departments. In an examination of 19 Accident and Emergency Departments, Lewis and Bradbury (1982) studied 260 Emergency nurses who believed the primary causes of increased utilization of Emergency Departments was based on the inability of patients to arrange appointments

with family physicians, as well as a general lack of knowledge concerning health care alternatives. Increased utilization of Emergency Departments by physicians has also been noted. Physicians will often instruct their patients to meet them in the department, or direct them to be seen by an Emergency physician if they are unable to see them (Vaughan & Gamester, 1966).

Although difficulty contacting family physicians after hours, on weekends, and holidays was identified as a reason for the increased pattern of utilization of Emergency Departments, Walker (1975) concluded that 66% of Emergency patients did not make any attempt to contact their family physician either due to the time of day, knowledge of limited office hours, or due to a belief by the patients that their illness would require the facilities and resources available within the Emergency Department. Walker also noted an increase in the number of Emergency Department visits from Thursday through Saturday. The rationale for the increase in utilization on these days was due to the patients' decision that they did not want to wait until Monday when they could possibly see their family physician. This lack of a desire to delay treatment over a weekend was also identified by Worth and Hurst (1989) as a cause of increased utilization of Emergency Departments. Kinney and Gerson (1983) also found a significant difference in the percentage of patients who came to Emergency departments during times when physician offices were closed. Findings from this study showed that 59% of the patients coming to Emergency after office hours had an established family physician. This finding further emphasized the impact of patients believing that Emergency Departments were their only alternative when their family physician was not available to them.

Torrens and Yedvab (1970) conducted a study of 1113 patients in four hospitals to study variations among emergency room populations. In this study three major roles of Emergency units were identified: (1) trauma care centres; (2) physician-substitutes when family physicians were not available; and (3) family physicians to the poor. The increase in

the number of patients utilizing Emergency departments for nonurgent conditions was also noted.

For some individuals, the decision to seek medical assistance from an Emergency Department was also based on the type of problem about which they were concerned. Crichton, Hsu and Tsang (1990) expressed the belief that some individuals were concerned that their family physician would be too judgemental or critical in dealing with a particular issue, therefore on these occasions patients sought care from a physician in an Emergency Department who would be more impersonal and less judgemental.

Additional factors have also been identified that affect the utilization of Emergency Departments. The overall increased mobility of the general population has led to difficulty for individuals and families who are frequently relocating in finding a family physician (Vaughan & Gamester, 1966; Kluge, Wegryn, & Lemley, 1965). Proximity to hospital facilities, within 15 to 20 minutes, has also been recognized as a factor in the increased utilization (Davidson, 1978; Wabschall, 1983). Similarly, consumer concern over symptoms and the availability of fast service, as well as convenience, were also perceived as significant (Lewis & Bradbury, 1982; Powers, Reichelt, & Jalowiec, 1983).

The use of the Emergency Department as a "second opinion" was examined by Wiley and Mohr (cited in Government of Alberta, 1989, p.35). A comprehensive questionnaire was given to patients in three Emergency Departments to determine the number of patients who had consulted another physician prior to the patient's decision to come to Emergency. Of those patients surveyed, 21% had been examined by another physician for the same health concern within 72 hours of the Emergency visit. Half of these patients had also been seen by a second physician within 24 hours of coming to Emergency. Patients explained that the need for additional visits was the result of feeling that their condition was either not improving or they were getting worse. The impact on

the health care system of "double doctoring", identified from this study, was significant on the increased utilization of health care services, including Emergency Departments.

Stratmann and Ullman (1975) surveyed 572 households in a community to examine the public perception of the role of the Emergency Department. They concluded that regardless of the seriousness of the illness, the overall increase in utilization was based primarily on changes in consumer demands. Generally the public viewed Emergency as a "last resort", when other alternatives were not available to them. In contrast, the public's changing attitudes for unlimited and immediate access to physicians, or "convenience medicine", was identified as an influential factor in the changing patterns of Emergency Department utilization during a 1989 study by the Government of Alberta on the utilization of medical services. This report identified inappropriate expectations of consumers for health care as having a significant effect on increased utilization.

Visits to Emergency Departments by geriatric patients has also been investigated to determine the impact of an aging population on utilization patterns. The increased utilization of Emergency Departments by geriatric patients over the last thirty years has also been noted by Saunders (1992), who reported 19% of Emergency visits by the elderly. A survey conducted by Hedges et al., (1992) found that rationale for seeking medical assistance through an Emergency Department were similar for the elderly and young. The patients generally felt too ill to wait to see their own family physician or were referred to the Emergency department by their physician.

A belief that individuals lack appropriate assessment skills to determine the need to either be seen by a physician, or to select the appropriate source of health care has also been expressed (Lewis & Bradbury, 1982). Worth and Hurst (1989), in a descriptive study to examine the appropriateness of Emergency Department visits, found that 14% of the patients seeking care, did so for inappropriate reasons. Both "trivial" and inappropriate requests (Cartwright, cited in Small & Seime, 1986) have been identified as

facilitating a concomitant drain of limited resources within the health care system (Siler-Wells, 1988; Government of Alberta, 1989).

With the advent of Medi-Centres, in the last few years, a common belief was that these new sources of health care would decrease the burden on the Emergency Departments (Jacobs, Garrett, & Wersinger, 1971), because nonurgent patients could choose to use such facilities. This has failed to become a reality. Lack of confidence in the competence of staff in Medi-Centres, and the belief that only hospitals carried a full range of facilities which Medi-Centres lacked, such as a Plaster room, lab and x-ray services, have been identifed by Truman (1993). The impact of freestanding Emergency centres, or Medi-Centres, on Emergency Departments has not led to a decline in the number of emergency visits (Ferber, 1983). Kinney and Gerson (1983) evaluated the impact of free-standing Emergency Centres on Emergency Departments and family physicians for the care of minor illnesses and injuries. To some extent the results of this study contradicted Ferber's results. Kinney and Gerson concluded that free-standing emergency centers may compete with Emergency Departments in the treatment of minor injuries, and both the Emergency Department and family physician in dealing with minor illnesses. For individuals who are not covered under a national or private health care plan, as in the United States, Andreoli and Musser (1985) identified that free-standing centres were an attractive alternative since they were perceived as less costly, more convenient, and faster.

In a study conducted by Snell, Jones and Yoder (1987), 85% of the sample studied had visited an Emergency Department within the last two years, whereas only 24% had visited a Medi- or Urgent Care centre. Although in this same sample 87% stated they would use an Emergency Department for a serious illness, no significant difference in choice of health care agency was noted for minor illnesses.

Previous health care experiences and early socialization factors have been found to influence utilization. In one of the first studies to examine not only Emergency department users but also nonusers, it was found that if the Emergency department was used as a source of health care during childhood, the same usage of the department would continue through adulthood (Jones, Ring, Jones, & Katz, 1985). Although the investigators hypothesized that users of Emergency departments were also more prone to a "crisis-type" of health care, this was not substantiated in the study: both users and nonusers of Emergency services were shown to practice regular preventive health care behaviors.

Although valuable data have been collected, knowledge of how an Emergency Department can best serve its patient population ultimately depends on individual departments assessing the needs of their own community in order to best meet their requirements. As early as 1960 the need for hospital Emergency Departments to plan strategically towards adapting to the changing utilization patterns of consumers has been identified (Lee, Solon, & Sheps). Jones, Jones, and Meisner (1978) as well as Davidson (1978) also emphasized the need to seek explanations of increased utilization based on the differences in demographic variables among hospitals and communities with different characteristics. It has been suggested (Gibson, 1973) that the Emergency department is the "last refuge to take care of failings elsewhere in the system" (p.60) and that it is the only area in the hospital which cannot control either the quality or quantity of its patients. Andren and Rosenqvist (1987), in a study of heavy users of an Emergency department over a two year period who had four or more visits during the previous year, concluded that 22% of the visits could be accounted for by changes in social networks over time and advocated the need for Emergency personnel to be aware of supportive agencies both internal and external to the hospital. However, as the demands continued to increase, Emergency Departments have experienced difficulty in meeting the ever-growing, and

changing needs of the public (Davidson, 1978). Although a transition in Emergency Department utilization has been identified, the method of delivery of patient care in Emergencies has not changed significantly since the 1950s (Blair, Sparger, Walts, & Thompson, 1982).

The majority of research conducted to date centers around individual Emergency departments. Since Emergency Departments differ greatly in the manner in which they serve their own community (Torrens & Yedvab, 1970), the generalizability of some of the findings and its application is slightly limited.

The Nonurgent Patient

It has been emphasized (Torrens & Yedvab, 1970) that although it is essential to determine the demographic profile of patients coming to Emergency departments, the characteristics of Emergency room populations are individual, based on the community served by the hospital. In a comparison of four hospitals, Torrens and Yedvab concluded that each Emergency serviced very different populations. Therefore, the characteristics of nonurgent patients described in the literature provides only an overview of the demographic profile.

The demographic profile of the nonurgent patient is varied. Several characteristics of nonurgent patients have been identified. The effect of gender on utilization rates is unclear. In several studies an equal number of females and males seeking care for nonurgent problems have been found (Lee, Solon, & Sheps, 1960; Jacoby & Jones, 1982; Jones, Ring, Jones, & Katz, 1985; Snell, Jones, & Yoder, 1987), while others have described a higher propensity for females to utilize Emergency departments for nonurgent conditions (Berman & Luck, 1971; Wabschall, 1983). Anson, Carmel, and Levin (1991) conducted a study to evaluate gender differences in the utilization of Emergency services,

and investigate previous research which explained the increasing tendency in utilization by women as a "magnification of symptom severity". The researchers only discussed the sample as individuals with "mild conditions", therefore, it can only be assumed that these conditions would be classified as nonurgent. However, no gender differences were found in the number of self-referrals, in rates of hospitalization, in symptoms, or in patient perceptions of women utilizing Emergency services. Some evidence of an increase in symptoms and perception of illness, however, was noted in 17-24 year old females in the study. The authors suggested that this conclusion may have been influenced by stereotypes of the individuals involved in the study. Another study conducted a year later concluded that more males than females, with a ratio of 1.7:1, sought care in an Accident or Emergency Department (Worth & Hurst, 1989).

Members of minority groups (Perkoff & Anderson, 1970; Berman & Luck, 1971), as well as individuals with less education (Gibson, 1973) have been identified as characteristics of patients utilizing Emergency departments with nonurgent conditions. Although there has been limited research on the influence of race in patients' use of Emergency departments, Perkoff and Anderson (1970), while examining the relationships among demographic characteristics, patient chief complaint, and source of medical care, found that Caucasians' illnesses were more likely to be urgent and surgical; whereas Blacks' health concerns examined in Emergency Departments were generally nonurgent. The influence of ethnic backgrounds, was investigated by Berman and Luck (1971) and this study supported the earlier findings by Perkoff and Anderson that predominantly young black females living in close proximity to an Emergency department sought medical assistance for nonurgent conditions. Even though these studies discovered a higher incidence of blacks and nonwhites as nonurgent patients, Jacoby and Jones (1982) concluded that race does not appear to influence whether an individual would be a repeater or nonrepeater to Emergency departments. The influence of cultural beliefs and

values of various ethnic groups have not been examined to determine if there is a correlation between how patients from different cultures view illness and how they would define a nonurgent health concern.

Low socioeconomic status has been reported to be a characteristic of nonurgent patients (Lavenhar, Ratner, & Weinerman, 1968; Gibson, 1973; Wabscall, 1983; Worth & Hurst, 1989). In their study, Lavenhar, Ratner and Weinerman concluded that patients with a lower socioeconomic status were more likely than other income groups to utilize the Emergency Department for nonurgent conditions. The impact of socioeconomic status was also evident in research conducted by Snell, Jones, and Yoder (1987), who investigated factors in choosing an Urgent Care Centre versus an Emergency Department. From this study, only one difference in the demographic characteristics of individuals who sought care from an Emergency Department or Urgent Care Centre was noted. Persons seeking care from an Urgent Care Centre generally earned a higher income than those who utilized Emergency Departments. The influence of a lower socioeconomic status on Emergency department utilization was identified by Jacobs, Garrett, and Wersinger (1971) who found that the rate of Emergency Department utilization increased by six times in areas of lower socioeconomic incomes.

Andren and Rosenqvist (1987), over a two year period, examined the characteristics of patients who had more than four visits to an Emergency Department during the previous year. A higher incidence of Emergency visits was found in individuals who were unemployed, living alone, lonely, and unmarried. Once again, the effect of socioeconomic status was evident. Despite some socioeconomic differences noted in these studies, Lavenhar, Ratner, and Weinerman (1968) suggested that some studies incorrectly assumed that all residents in a particular area were from the same social class, thus affecting the findings.

Nonurgent patients have also been characterized as frequently residing in inner city areas (Solon & Riss, 1972; Gibson, 1973). These findings may be closely correlated with the influence of low socioeconomic status (Lavenhar, Ratner, & Weinerman, 1968). When evaluating the results of studies conducted in hospitals located in inner cities, it is necessary to consider that generally these individuals utilize the Emergency Department as their regular source of health care, therefore such studies will subsequently report extremely high numbers of nonurgent visits (Powers, Reichelt, & Jalowiec, 1983).

Stressful life events during six months to one year prior to the Emergency visit were also found to be a characteristic of the nonurgent patient (Parker, 1982). An increase in the number of Emergency visits for nonurgent conditions was apparent in these patients under study. Patients who lived in closer proximity to Emergency Departments than to other sources of health care have also been identified as prone to rely more on Emergency Departments for nonurgent health concerns (Wabschall, 1983).

Research to investigate the demographic profile of nonurgent patients has identified the influence of gender, education, race, socioeconomic status, employment, stressful life events, and proximity to an Emergency Department. Differences in research findings have been noted and reflect the uniqueness of the communities served by individual Emergency Departments. Research into the demographic profile of nonurgent patients in a specific community is necessary to explicate more accurately the characteristics of this classification of patient.

Result of Changing Utilization Patterns of Emergency Departments

As a result of the changing pattern of utilization by nonurgent patients, open conflict between staff and nonurgent patients develops (Yoder & Jones, 1981). In a study of nurses' perceptions and attitudes regarding changing Emergency department use, the

nurses' perceptions were that patients with minor illnesses or injuries should not come to the Emergency Department. Eighty percent of the nurses indicated that between 26% to 58% of the patients could go elsewhere. Patients who were identified as not being suitable for treatment in the Emergency Department were those with minor illnesses, chronic conditions, or patients who decided to come due to convenience. Convenience for the patient was identified by the nurses as the most common type of misuse. Since nurses represent the largest group of health care professionals, it was concluded that their perceptions are extremely influential in determining how patients are viewed by the remainder of the health care team (Yoder & Jones, 1981). In fact, nurses have been identified as the most influential group of professionals in determining patients' perception of care within a hospital (Carter & Mowad, 1988; Steiber, 1988).

"Moral categorizations" by the nurses, concerning the legitimacy or illegitimacy of the Emergency visit, was considered crucial in determining the quality of service to the patient (Roth, 1972). Based on observations of six hospital Emergency departments, Roth examined the effect of moral judgements on the quality of patient care. It has been emphasized that irrespective of professional training, moral neutrality is not ensured (Becker et al., cited in Roth, 1972). Judgements regarding how a patient is dressed, his/her perceived socioeconomic status, and the validity of the illness are made quickly by Emergency staff. The most influential individual in the moral categorization of patients is the first person to "process" the patient. Impressions of all staff who will subsequently care for or interact with that patient may be directly influenced. The inherent belief by a large number of staff was found to be that if the conditions were assessed by the staff as minor, patients were "abusing" the Emergency department. Staff in this study estimated the percentage of inappropriate visits by patients to be between 70-90%. When a comparative classification was conducted by Roth, the actual percentage of patient visits which could be assessed as inappropriate was in fact 20-25%. Staff also believed that

patients should not decide to seek care in Emergency based on convenience and quick service.

This study, conducted by Roth (1972), served to identify factors which were instrumental in negatively affecting Emergency staffs' judgement regarding the worth of a patient, as well as the illness. The effect of such moral categorizations on the quality of patient care was valuable in identifying the dangers of such judgements and their influence on other staff members.

Roth (1972) expanded his research to investigate staff and client control strategies. The study was conducted in five hospital Emergency Departments. Staff control strategies utilized in Emergency were identified as ignoring or avoiding patients and keeping patients waiting. If the patient was perceived by the staff to be a "fake", the patient would be made to wait longer. Another control strategy was used when staff would ensure that the experience of being seen in Emergency was not too convenient for the patient, so as, possibly, not to increase the chance that the patient would decide to come back more frequently to Emergency as a source of health care. Control over visitors was also observed by Roth. Visitors were perceived by the staff to have no rights in Emergency, other than when the staff required their assistance. Limiting of information to patients was also identified as a very powerful control strategy utilized by Emergency staff.

Use of control strategies by patients was also identified. Since the majority of self-referred patients came to Emergency with minor illnesses, the control strategy used was based on past experiences. The patients had the power to seek care elsewhere if they had a negative experience in the department in the past. Methods of control used by the patients to influence when they would be seen were also apparent. At times, becoming demanding or overtly angry and threatening reporting the staff to their superiors, was effective. Similarly, presenting symptoms in a convincing manner positively influenced

when the patient would receive care. Becoming overly demanding and being perceived as a "complainer", however, could result in the Emergency staff making the patient wait even longer.

Patients who were identified as "experienced", in receiving care in the Emergency department in the past, were seen as having distinct advantages. Experienced patients were more selective as to when they came into Emergency, choosing a time when they had found the department less busy. This ensured faster care. Through experience, patients were observed to be more adept at manipulating the system to obtain faster and more specific treatment. Based on previous experiences, these patients also have an established acceptable "waiting" period. When they have not been cared for within this time frame their complaint is received more appropriately by the staff.

In a study conducted in 1982 by Lewis and Bradbury, on attitudes and expectations of nurses working in Emergency Departments, nurses expressed satisfaction in caring for acutely ill patients, however they were frustrated and "resentful" with nonurgent patients. Although the nurses recognized situations which resulted in patients with nonurgent conditions seeking care in an Emergency, 97% agreed that the Emergency Department was not the appropriate source of health care for nonurgent patients. The nurses also unanimously agreed that a large portion of their time was used to care for nonurgent patients. The work associated with nonurgent concerns was disliked by a large number of the Emergency nurses, who preferred the use of advanced skills and challenging tasks associated with caring for critically ill patients. This desire for a fast-paced, changing environment was identified by Burns, Kirilloff and Close (1983) to be closely associated with satisfaction. In a study involving 160 Emergency nurses from five community hospitals, sources of stress and satisfaction were identified. The main sources of satisfaction for Emergency nurses were patient care, knowledge and skills, and interpersonal relationships. The greatest sources of stress, however, were unit

management, patient care, and interpersonal relationships. What is evident from this study was the close relationship between satisfaction and stress for Emergency nurses.

Despite nurses' beliefs that a nonurgent illness or minor injury should not be treated in an Emergency Department, nonurgent patients seek health care due to concern for their well-being; they feel in need of assistance (Powers, Reichelt & Jalowiec, 1983), and are unwilling to delay treatment for a long period of time (Vaughan & Gamester, 1966). Patients' decisions to visit the Emergency Department are based on their feelings of acceptance and their confidence in the ability of the health care professionals to fulfill their expectations (Gibson, 1973). Immediacy and expediency of care in Emergency departments (Jacoby & Jones, 1982; Pisarcik, cited in Snell, Jones & Yoder, 1987), perceived urgency of the problem (Kluge, Wegryn, & Lemley, 1965), and changing beliefs regarding the role of the department (Gibson, 1973), reflect consumer attitudes towards Emergency utilization. The importance of acknowledging and incorporating a patient's perception of illness, as opposed to focusing solely on the admitting diagnosis, is also recognized (Cranwell, cited in Molde, 1986). It has been theorized that conflicting perceptions could result in patient noncompliance, dissatisfaction with professional health care, and, ultimately, inadequate clinical care (Good, 1977; Eisenberg, 1977; Kleinman, 1988; Mechanic, 1986).

In response to the increased number of nonurgent patients in Emergency departments, strategies have been developed in various facilities to address the issue of nonurgent patients. A method to screen emergency conditions through a triage process has been suggested by refusing care to nonurgent patients and redirecting them to a clinic (Derlet & Nishio, 1990). Through the use of specific guidelines, a triage nurse assesses the patient and may subsequently refuse to provide Emergency treatment to nonurgent patients, referring them to a clinic. The result of this strategy has been shown to decrease dramatically the volume of patients utilizing Emergency and to ensure greater attention to

more acutely ill patients. Refusing to treat individuals in this manner may not be a realistic alternative in many facilities and may have negative implications in terms of the perception of the quality of care, patient satisfaction, and reputation of the hospital itself. Results from this study showed a 99% compliance rate, however, it is questionable as to the care the remaining 1% of the patients who did not comply received and the impact on future decisions of patients when they are selecting health care alternatives.

An innovative strategy, which has been implemented in some facilities as a result of the changing utilization patterns of Emergency Departments by nonurgent patients, is a fast track method of care delivery for them (Hodges, 1990; Covington, Erwin, & Sellers, 1992; DiGiacomo & Hatzipetro, 1992). In response to the changing pattern of utilization of Emergency Departments, care of nonurgent patients is not perceived as trivial or a misuse of the system, but rather as an integral component of Emergency care. Through the triage of nonurgent patients to an area of the department specifically designated for fast track, many advantages have been identified which decreased previous frustration of both the staff and patients. Previous concerns regarding the quality of care provided to nonurgent patients in Emergency, long patient waits, and an increasing number of patients leaving without treatment, have shown drastic improvement (Hodges, 1990). The effect of implementing a fast track system of care has resulted in increased patient satisfaction concerning the quality of care and decreased stress and job dissatisfaction among the Emergency staff. Fast track has been demonstrated to be an effective method of responding to the needs of the health care consumer in a cost-effective manner (DiGiacomo & Hatzipetro, 1992).

Traditionally the role of the Emergency Department has been for the care of only trauma (Roth, 1971) and urgent patients (Stratmann & Ullman, 1975). The changing patterns of utilization necessitate the evolution of the role of Emergency in ambulatory care (Gibson, 1973; Jacobs, Garrett, & Wersinger, 1971). The burden of adapting to the

changes in utilization lies primarily on the Emergency staff (Jacoby & Jones, 1982). Siler-Wells (1988) concluded that failure to identify the role of professionals in adapting to the changes in utilization may be perceived as a threat and result in protective behavior by the staff, rather than a positive, cooperative manner.

Further investigation is required by individual hospitals to provide a more accurate, comprehensive view of the nonurgent patients in their community. This issue may also emphasize the concern expressed in an earlier study by Davidson (1978) who confirmed the findings of several studies addressing the demographic profile of the nonurgent patient. Davidson stressed the belief that greater understanding of the growth of Emergency Department utilization may be facilitated through more indepth research to examine enabling and illness factors of patients seeking care for nonurgent problems.

Evidence in the literature supports the increased utilization of Emergency Departments by nonurgent patients. Considerable research has been conducted to provide an overview of the demographic profile of the nonurgent patient and the factors that affect utilization of Emergency Departments. Since Emergency Departments differ greatly in the manner in which they serve their own community, the generalizability of the findings and application is somewhat limited. Investigation into the effect of the increasing number of nonurgent patients on Emergency Departments has identified frustration and resentment, open conflict, moral categorizations, overcrowding of Emergency facilities, heavy staff workloads and decreased job satisfaction, all of which influence the quality of patient care. A void in the research is apparent. No research has been conducted to investigate the impact of the changing patterns of utilization on the nonurgent patient. To facilitate an understanding of this impact, research which would focus on the experience of the nonurgent patient in the Emergency Department is required.

Chapter 3

Methods

A review of the literature demonstrated the presence of empirical or quantitative research in the area of Emergency Department utilization by nonurgent patients. Emphasis in the existing literature has been placed on a universal or etic dimension, through the analysis of demographic variables, utilization patterns, and the effect of the increase in nonurgent patients.

A void in the existing research was apparent. Research had not been conducted to investigate the effects of the changes in Emergency department utilization on the nonurgent patient. An indepth description and interpretation of the emic or personal perspective on nonurgent patients, conducted in a naturalistic setting, was still lacking. Therefore, a qualitative method was deemed most appropriate. Qualitative research extends knowledge further through inductively describing, documenting, and analyzing the experience and culture of nonurgent patients in a realistic, holistic, and comprehensive manner (Leininger, 1985). In addition, the use of qualitative research effectively explicates and ultimately clarifies previous empirical findings (Glaser & Strauss, 1966).

Design

A descriptive, interpretive ethnographic type design was utilized to answer the question, "What is it like being a nonurgent patient in Emergency?". Ethnography is a "way of collecting, describing and analyzing the ways in which human beings categorize the meaning of their world" (Aamodt, 1982, p.30). This design facilitates the generation

of knowledge in areas where little or no research has been conducted and seeks to understand the meaning individuals ascribe to an aspect of life (Leininger, 1985; Spradley, 1979). Through ethnographic methods, the understanding of individuals' experience of coming to an Emergency Department and how this knowledge influences human behavior within a particular culture or setting can be attained (Field & Morse, 1985; Aamodt, 1982; Leininger, 1985; VanMaanen, 1988). This design facilitates a greater understanding of the meaning individuals place on experiences with a particular culture.

Since behavior can best be understood within the context of the most "natural", "undisturbed" state (Hammersley & Atkinson, 1983), any experimental, or artificial research setting would limit and restrict the true understanding of the individuals' experience. Ethnographic methodology, through the process of observation, interviews and demography, facilitate the understanding of behavior from an emic or personal perspective (Field & Morse, 1985).

Informant Selection

A purposeful selection of informants was utilized to ensure the representativeness of the population under study (Hammersley & Atkinson 1983; Morse, 1991), who could speak of their experiences (Spradley, 1979; Fetterman, 1989), and who would facilitate the emerging theory (Bogdan & Biklen, in Field & Morse, 1985). The use of this selection method was appropriate since the investigator was "selecting the informants according to research needs" (Morse, cited in Chinn, 1986, p.184).

The focus on nonurgent patients arose from the literature review in which there was support that this patient group faced the greatest discrepancy as to the legitimate use of the Emergency Department. Historically, the appropriate utilization of Emergency Departments was based on the mandate "to provide immediate and temporary care to the

acutely ill and injured" (Yoder & Jones, 1981, p.160). Thus informants were selected based on the following criteria: ambulatory patient; 18 years of age or over; self-initiated visit; classified by the nurse as nonurgent; able to understand and speak English. Exclusion criteria included: pregnancy; admission to Emergency with a psychiatric illness; and changing status from nonurgent to urgent and/or emergent. Selection of informants occurred at different times of the day and days of the week (including statutory holidays and weekends), and consideration was given to such demographic variables as gender, race, and age. These inclusion and exclusion criteria were selected to ensure that data collected would contribute towards a realistic understanding of the experience of nonurgent patients in Emergency. The nonurgent patients' first hand experience with the Emergency Department and their perceptions facilitated richness and ultimate saturation of the data (Field & Morse, 1985).

Since this study examined the culture of nonurgent patients, it was important to obtain information from other individuals who influenced the environment, and ultimately, the experience of the patient such as the staff, as well as family or friends. Secondary informants included nurses and physicians working in the department. Family and/or friends who accompanied nonurgent patients to the Emergency Department were also asked to participate.

As the Emergency Department treats emergent, urgent, and nonurgent patients, it was important to differentiate between the experience of the nonurgent patient from the other two categories. Consequently, urgent patients were interviewed to facilitate this process. It was understood that should the urgent patient have become more ill, the researcher would have terminated the interview immediately. For safety reasons patients with emergent conditions were not included in the selection of informants.

The number of informants remained a "tentative" number, since the true number was dictated by the quality and richness of the data. Further selection occurred on the

basis of the need to identify categories that stemmed from the evolving analysis. The investigator further promoted adequacy of the informants by ensuring accuracy and completeness of the data. Due to the amount of data collected and analyzed during this ethnographic study, the number of primary informants was limited to nine. Data collection was concluded when saturation of categories was evident.

Access to Sample

Emergency patients who had been identified as nonurgent by the triage nurse were given information on the study by the triage nurse and instructed to read the information letter (Appendix A). If interested in participating, the patient informed the Unit Clerk as to his/her willingness to talk to the researcher. The researcher then explained the study, including the purpose, possible benefits, and role of the informant. All informants were requested to sign a written, informed consent regarding their willingness to participate in the study.

Once the nonurgent patient had agreed to participate, family and/or friends who had accompanied the patient to the Emergency Department were given an information letter by the investigator which explained the study, the informant's role as well as the family and/or friend's role (Appendix B). After allowing time for family and/or friends to read the information letter, they were asked if they would be willing to participate in the study. The researcher then explained the study further, including the purpose, possible benefits, and role of the family member and/or friend.

Urgent patients who were well enough to participate in the study, as classified and assessed by the triage nurse, were asked by an Emergency nurse if they would be willing to discuss this study. If they agreed to participate, the researcher explained the study, including the purpose, possible benefits, and their role. An information letter regarding

the research project was then distributed to the patient (Appendix C). Ample opportunity was given for any concerns or questions to have been discussed at any time.

Information letters regarding the research project were distributed to nurses, physicians, and support staff during staff meetings (Appendix D). Those individuals interested in participating were given a number to contact the investigator. Arrangements were then made to meet with interested staff members to further discuss the research project and their roles.

Data Collection

This research study was conducted in a large (approximately 1000 bed) tertiary acute care hospital in Western Canada. The investigator began by spending periods of time sitting in the Emergency Department waiting room making initial observations. Following completion of these observations, interviewing began.

The initial entry into the research setting served to provide additional time with the Emergency staff to answer any further questions regarding the study and the staff members' role. It was important for the researcher to facilitate the establishment of a conducive, nonthreatening rapport with the staff, and to ensure that they were well-informed regarding the process of obtaining informants and that they were aware that it would not add greatly to their workload. Facilitating such a relationship with the staff also promoted a more "naturalistic" atmosphere within the department, as opposed to having the staff alter the setting due to a level of discomfort with, or as a result of feeling threatened by, the investigator.

Each time the researcher was on the unit to obtain informants, a folder containing patient information letters was placed at the Emergency desk. On the front of the cover was a brief outline of the process, to assist the triage nurse. A brief review of the process

was provided by the researcher to ensure the nurse's level of comfort in her role. An opportunity was provided to answer any questions or address any concerns. Once it was apparent the nurse felt comfortable and well-informed, the researcher stepped away from the Emergency desk, and sat at the back of the desk or in an enclosed reporting room adjoining the desk area. The triage nurse was always kept informed as to where the researcher was, to facilitate easy accessibility.

Once a nonurgent patient agreed to participate in the study as a primary informant, the investigator asked the patients if they wanted to begin the interview while they waited to be called, after they had been seen by a physician, or at home. Interviews were conducted in a private examination room or in a quiet room adjoining the Emergency Department. Demographic information was also obtained during the interviews (Appendix E). These data were used to describe the group of informants. The Charge Nurse agreed to send a nurse into the room next to the Emergency area when it was the patient's turn to be seen by a physician, to ensure that the interviews would not delay treatment of any patient. The Emergency examination rooms were all equipped with intercoms to ensure that their care was not delayed as well. When it was the patient's turn to be seen by a physician and his/her name was called, the interview ceased. Second interviews were scheduled between one and two weeks following the initial interview.

Interviews were conducted using open-ended questions. To facilitate the establishment of an effective rapport and to elicit information, three types of ethnographic questions were utilized during the interviews (Spradley, 1979). Descriptive questions such as, "What is it like being a patient in the Emergency Department?", assisted the investigator in establishing the setting through the patients' use of language (Frake, cited in Spradley, 1979, p. 85). Structural questions which helped to identify how the informants had organized their cultural knowledge were asked concurrently with that of descriptive questions. An example of a structural question , "How did you arrive at the decision to

come to Emergency?". Contrast questions were also asked during the interviews which further elicited meaning from the identification of differences and similarities, as in the question, "What types of illnesses or health concerns do you feel should be seen by a Doctor in an office, and what types should be seen in an Emergency Department?". Interviews lasted between 30 to 90 minutes. The length of the initial interview of primary informants was determined by the informant based on how well they felt at that time. Second interviews were beneficial for clarification of information discussed during the initial meeting. New information was also obtained at this time since informants had the opportunity to reflect on the experience. All interviews were tape recorded and later transcribed for the purpose of data analysis.

Interviews with secondary informants were also conducted. These interviews, scheduled at times convenient for physicians and nurses in Emergency, as well as for family and friends of the primary informant, provided for enrichment and added depth of the data. The investigator also collected data from four urgent patients in the Emergency department by posing questions similar to those asked of nonurgent patients. This helped differentiate between the experiences of nonurgent and urgent patients. Data from urgent patients were collected following treatment and once they were admitted on a nursing unit.

Data Analysis

The process of data analysis was critical to the credibility of the research (Knafl & Webster, 1988). Data analysis was conducted simultaneously with that of data collection (Glaser & Strauss, 1966; Hammersley & Atkinson, 1983; Robertson & Boyle, 1984; Spradley, 1979).

Following approval of entry to conduct research in the Emergency Department, several hours were spent sitting in the Emergency waiting room and in the Department to facilitate a descriptive analysis of the culture. This period of time provided the opportunity to observe the process of nonurgent patients being admitted to the Department, and to observe patients while they waited and their interaction with Emergency staff.

Fieldnotes were gathered at different times of the day and on different days of the week to establish a clearer view of the culture and setting of the Department. Periodic withdrawal from the setting provided the opportunity to record further impressions, and to reflect on the observations made. Analytic field notes and memoranda were compiled which consisted of descriptive notations of the setting, social relationships, and personal impressions. A checklist, developed by Spradley (Hammersley & Atkinson, 1983, p. 156), was utilized as a guide to facilitate greater depth and completeness of fieldnotes. Notations were organized according to nine elements: space, actor, activity, object, act, event, time, goal, and feelings. Following transcription of the extensive fieldnotes, further coding to draw out meaning and context was added on the left margin of the page.

The initial observation periods were beneficial for the researcher as they provided additional opportunity to begin to ask internal questions and to identify some issues in relation to the observations made. Once a number of observation periods were completed, the researcher identified the need for additional information regarding such issues as the admitting process and utilization of the Emergency waiting room by patients from other departments. Comments patients made, as well as their behaviors while waiting in the Emergency waiting room, served to generate questions and to provide the researcher with more "meaning" and depth into the unveiling of the culture.

Once an interview was completed, it was carefully transcribed from the audio tapes and checked for accuracy. The format of the transcriptions facilitated the coding process

within the large margins on either side. Each tape was identified with a code and listened to while the transcript was read to ensure accuracy, as well as to note any inflections. Reading each transcript three times initially added to the investigator's familiarity of the content. Four copies of each transcript were made for use in data analysis.

Analysis was initiated by careful reading of the data obtained; analytic memos and field notes contributed to the identification of definitive concepts which provided direction for further observation (Blumer, cited in Hammersley and Atkinson, 1983). Implicit coding, thinking systematically about the data based on major categories (Glaser & Strauss, 1966), began at the initiation of the research. Progressive focussing took place as the scope of the research question was further clarified during the analysis and as the investigator sought to verify and test explanations (Hammersley & Atkinson, 1983). Triangulation, the constant comparison of information within and between informants, was essential to ensure greater "quality and accuracy" of the findings (Fetterman, 1989, p.91).

Consistent coding methods were utilized during the analysis of each interview. Upon completion, the interviews were carefully transcribed from the audiotapes and checked for accuracy. Each tape was identified with a numerical code and listened to while the transcripts were read to ensure accuracy, to note any inflections, and to add to the investigator's familiarity with the content.

First level coding, color coding each interview in the left margin, was conducted to facilitate accurate identification of the interviews (Field & Morse, 1985). Two different colored highlighting pens were used. The first color identified the informant; and the second noted whether it was the first or second interview.

Large margins were provided in each of the transcripts. Interpretations and additional notes during second level coding were placed in the right margin. Analysis of the transcripts was conducted through implicit coding of the data (Glaser & Strauss, 1966).

Through the process of pattern, or third level coding, ten analytic categories, or emerging themes were identified (Miles & Huberman, cited in Burns, 1989, p.47). A manual cutting and sorting method was utilized to initiate a more indepth, detailed analysis. Significant phrases or comments were cut out of each of the transcripts and placed into envelopes labelled with one of the initial categories (Bogden & Biklen, 1982; Field & Morse, 1985). This manual sorting method enabled greater manipulation of the data. Once a category became exceedingly large, continuous sorting of the data was conducted which facilitated more detailed, indepth analysis of emerging patterns and themes, resulting in further sub-categories (Knafl & Webster, 1988). This process of data analysis continued until all categories were fully analyzed into subcategories. Sampling and data analysis continued until each category was saturated (Corbin, 1986), leading to a detailed description of the culture (Robertson & Boyle, 1984) and a deeper understanding of the experience of the nonurgent patient in the Emergency department.

Reliability and Validity

Assurance of reliability and validity was of primary concern throughout the research process. The credibility of the findings was based on the evidence that efforts had been made to optimize reliability and validity.

Critical to the reliability of the study was the "sample selection and instrument development" (Field & Morse, 1985, p.176). Representativeness of the primary informants was evaluated by the investigator. Informants were selected who had relevant information and experience coming to the Emergency department as a nonurgent patient, with a varying number of visits, ranging from 3 to 12. The risk of "elite bias" was decreased through the careful selection of informants (Sandelowski, 1986). Four male and five female nonurgent patients were interviewed with variation in demographic

characteristics, educational preparation, and ethnic background. Two patients spoke limited English and required the use of a translator. The husband of a patient, as well as the researcher, facilitated the translation of these two interviews. Ensuring a diverse group of informants was critical to the representativeness of the sample with consideration given to the multicultural patient population, including patients residing in the inner city.

Reliability, or the stability and consistency of results (Field & Morse, 1985; Sandelowski, 1986) was enhanced by the accurate documentation in the final report of the details and methods of the research process and design. The data collection process consisted of objective, comprehensive recording of field notes, the taping of all interviews, and verification of data with the informants, which served to further strengthen the reliability of the study (Morse, 1986). Constant review of the collected data by a thesis supervisor ensured the adequacy of the "decision trail" (Sandelowski, 1986, p.27) and the formulation of accurate conclusions. Consideration was given to the social context of the study. Lengthy observation periods facilitated a detailed description of the culture and appropriate sample selection. Efforts were taken by the researcher to establish a non-threatening environment to prevent the loss of the "natural" characteristics of the setting. Caution was taken to avoid "going native" and thereby lose objectivity during data analysis. Once all the interviews were conducted, a period of time was taken which served to distance the researcher from the data (Bogdan & Biklen, 1982).

Data were collected from a variety of sources, nonurgent patients, family members, and Emergency staff, which facilitated greater depth of the data and added to the reliability of information obtained through constant clarification (Robertson & Boyle, 1984). Interviews with "negative cases" (Field & Morse, 1985, p.106), or urgent patients, served to clarify and differentiate the experiences of the nonurgent patient (Robertson & Boyle, 1984). Respondent validation of information was sought through the continuous

verification of findings during interviews and through secondary interviews with five of the nonurgent patients (Hammersley & Atkinson, 1983; Spradley, 1979).

Validity, an essential element of the research design, refers to gaining the true essence and meaning of the phenomenon under investigation (Leininger, 1985). The elements of history, maturation, informant mortality, the influence of the researcher on the informants, and selection of observations were considered to ensure the validity of the study (Field & Morse, 1985).

The incidence of error was minimized by conducting two interviews with some of the primary informants. Through the verification of the data by the informants, validity was increased. To ensure that the data obtained were accurate and represented the true reality and meaning of the experience, purposeful selection of informants, and constant comparison techniques were utilized (Strauss, 1987; Glaser & Strauss, 1966). A three level method of coding was used to develop categories, to identify appropriate content, and to extract meaning from the data (Knafl & Webster, 1988).

Data collection was conducted over a period of four and a half months which promoted the validity of findings (Robertson & Boyle, 1984) in that it facilitated simultaneous data collection and analysis. Care was taken by the researcher during fieldwork to maintain as "natural" a setting as possible. Initial observation periods assisted the Emergency staff in becoming comfortable with the researcher and in promoting a non-threatening atmosphere. During the course of the research, no organizational changes occurred which would have added the possible effect of history on the research project.

The status of the researcher was an aspect of consideration in the validity of the study. Familiarity of the environment of the Emergency Department was an asset in understanding the culture within the clinical setting (Field, 1989). The researcher had not worked in the clinical area for approximately five years which helped to decrease any further bias and, subsequently, to promote objectivity. Informants were made aware that

although the researcher was a nurse, she did not work in the Emergency Department. The use of self as the research instrument (Field, 1989) necessitated continuous awareness on the part of the researcher that observations were made accurately and objectively.

Participant mortality occurred through the withdrawal of one primary informant during the study due to the inability to establish a convenient time for the interview. Secondary interviews of two of the nonurgent patients were not conducted due to sudden relocation of the informants. Although an additional nonurgent patient had also agreed to speak with the researcher regarding her involvement in the study, she appeared quite anxious when her role was discussed. This patient was a new immigrant and appeared very concerned regarding possible repercussions, external to the hospital, should she be involved. The researcher was quick to observe the individual's concern and so suggested that she consider not being involved. The patient was thanked for her interest and honesty. The remaining informants were very accommodating and interested in their participation.

Credibility of research findings is largely determined by the efforts of the investigator to maintain rigorous standards in ensuring reliability and validity of the research process. Throughout the study, strategies were utilized which promoted the stability, consistency, and truth of the quality of the evidence.

Ethical Considerations

This study was examined and approved by the Ethics Review Committee in the Faculty of Nursing at the University of Alberta as well as by the Hospital Investigational Review Committee. The protection of human rights was ensured throughout the course of the study. Access to potential informants was requested by the triage nurse. Due to the ability of the patients to refuse to discuss the study, the risk of possible coercion was

minimized. The investigator approached the family and/or friends of the nonurgent patients once they had agreed to take part in the study. The researcher emphasized that the care of their family member or friend would not be affected in any way if they decided not to participate in the study. The Emergency staff were not coerced into participating in the study. Following the discussion concerning the research study at the staff meeting, the nurses and physicians interested in participating contacted the investigator. The investigator emphasized that participation in the study was voluntary, and participants were free to withdraw at any time before or during the study by informing the investigator. Strict confidentiality of information obtained regarding individuals and the institution was maintained. Transcripts were numerically coded. Names or other identifying information from the tapes were not transcribed. Subjects were informed that comments made by them could be used in talks or articles about the study, however their names would not be used at any time. The code sheets with corresponding names, addresses and telephone numbers were destroyed at the end of the study. All tapes and transcripts have been kept under lock and key. If further research is proposed, appropriate ethical review will be sought.

An informed consent (Appendix F, G, H, and I) was obtained from each participant. When the informant had difficulty reading English, for the purpose of obtaining an informed consent, the investigator read the consent aloud and taped the process on a separate tape, which was filed in a secure locked cabinet. Once the investigator had explained the purpose of the study and the informants' role had been clarified, the individual was asked to verbalize his/her understanding of the study and its purpose. Two consents were signed and one copy of the signed consent was given to each informant. When the consent was obtained on tape, it was kept separate from the data to further ensure anonymity.

The main risk identified for the informants was the possible discomfort created by divulging feelings and the meaning they attributed to their experience of what it was like being a nonurgent patient in Emergency. The researcher was sensitive to the needs of the informants in order to counteract this risk.

Chapter 4

Findings

Data were obtained through interviews with nine nonurgent patients, four urgent patients, two family members, and six Emergency staff. To facilitate a greater understanding of the findings, an overview of the sample will be provided. A model of the decision-making process patients utilized to determine where they should seek health care was developed from the interviews of the nonurgent patients in the Emergency Department (see Figure 4.1). Each step in the decision-making process will be discussed. Following a descriptive interpretation of this process, a comparison is done to establish how the experiences of nonurgent patients related to those of urgent patients. As the environment of the Emergency Room and the Emergency staff influence the experiences of nonurgent patients, these will also be discussed.

Description of Primary Informants

Nine nonurgent patients were interviewed as primary informants; four males and five females. Ages ranged from 27 to 76 years. To ensure representativeness of the informants, individuals with various ethnic and cultural backgrounds were sought: Ukrainian, Spanish, Native, Dutch, and Irish. The educational preparation varied from grade 6 to college degrees and one individual with university education. Five of the informants completed schooling between grade 10 and 12. The marital status of the informants varied from being married (four), single (four), or living commonlaw (one). A diversity of employment was noted, from a private business owner, government employee,

student, janitor. Two individuals were retired, while the remaining three were unemployed, two of whom were on Social Assistance.

The number of occasions the informants had come to Emergency ranged from two previous visits to 12. The length of time informants spent in the Emergency Department, from admission to discharge, was between 46 minutes to three hours and 17 minutes. Interviews were conducted on all shifts, on weekends, and statutory holidays. Two informants had difficulty communicating in English. The husband of an informant was utilized as a translator. As well, to facilitate effective communication, the researcher conducted the majority of an interview with another informant in Ukrainian.

The Nonurgent Patient

Reasons for Coming to Emergency

Nonurgent patients identified a variety of reasons for seeking health care within the Emergency Department. Pain relief from reactive arthritis for one individual (Mr. A.), was the primary reason for his visit to the Emergency Department. The patient discussed his usual approach of dealing with his chronic pain: meditation (trying to "talk the pain away"); distraction with other activities; focusing "natural opiates to central points to increase relief of pain"; and the use of prescribed analgesic from his own physician. Once Mr. A.'s routine of attempting to relieve his pain proved to be unsuccessful, he believed his only recourse in the early hours of the morning was to go to an Emergency Department to obtain stronger analgesic. Mr. A.'s decision was based on the facts that he had exhausted his efforts in relieving his pain, he was not a resident of the city, and he felt he needed to seek clarification whether the pain was the result of his arthritis or due to another health problem. Since he was not at home near his own family physician, he felt it was

appropriate to seek health care in the nearest Emergency Department. The decision was also based on his belief that Emergency Departments offer expedient care in the presence of advanced technology and are able to involve specialists if needed.

Mr. B. also sought pain relief as well as clarification regarding the extent of an injury that occurred while playing hockey early in the morning. He arrived in the Emergency Department at 0230 hours stating he was experiencing pain in his toe as the result of bleeding under the toenail. In addition, he was also concerned that his finger was fractured. Mr. B. perceived the Emergency Department to be his "best" alternative since Medi-Centres were closed. He also believed the staff in Emergency Departments were not as busy on nights. The proximity of the hospital to where he was playing hockey, its easy access in terms of parking, and ultimately its greater convenience influenced his decision. Although he emphasized that the public should "not encumber the tax system " as they currently do through "abuse" of the health care system, Mr. B. believed strongly a visit to the Emergency Department was more than justified in a situation such as his. During our conversations, Mr. B. also discussed the procedure of calling in sick at his place of employment. A letter from a physician was required to validate an employee's illness. It may be that an inherent reason for Mr. B.'s visit to Emergency was to not only seek medical attention for his minor injuries, but also to ensure possible validation should he decide to call in ill for work the next morning. Mr. B. was examined by an Emergency physician, and released with a bandaid.

Ms. C. came to the Emergency Department as the result of feeling nauseated and increasingly weak for the previous two and a half to three days. Her rationale for selecting this facility was that it was the closest to where she lived. Also she had come to this Emergency two days ago for treatment of the same illness as well as pain relief for a severe headache. Ms. C. had become sicker since her previous visit and wanted to know why she was not getting better. Ms. C. stated that she very seldom sought out medical

attention but since she felt her condition was "different" she needed to know what was wrong with her. Therefore, she came into Emergency because of the severity of her illness, her records were there from her previous visit, and she was unable to see her own family doctor, as it was a Sunday.

Ms. D. decided to come to Emergency to seek treatment of a rash and swelling on her face and cheeks which she had experienced for the last three days. Since she thought the rash might be the result of an allergy to Tylenol, which she had been taking for a fractured wrist, she decided to stop taking the medication to see if there would be an improvement. When this method of self-care proved to be unsuccessful, Ms. D. called her own physician only to find out that he was on vacation. The physician relieving her family physician was unable to see her "right away", therefore she decided to seek medical attention via an Emergency Department, and she chose this Department as it was the closest to her home. Ms. D. was very quick to point out that she realized her "problem" was not a high priority based on other individuals in the Emergency Department and subsequently expected to wait to be examined by a physician.

Mr. E. came into Emergency to get a prescription of Dilantin refilled, which had run out on that day. Mr. E. had gone to a clinic in the Inner City to obtain a new prescription, however could not be seen as fast as he desired and decided to then go to the nearest Emergency Department knowing that he would be sure to see a physician there. The informant apparently had a family physician but his office was too far away since Mr. E. did not own a vehicle. The hospital was only five minutes away and was much more convenient. He felt that "time" was an important factor and he wanted to pick the "quickest and easiest" route to medical care. Mr. E. said he had identified other alternatives, but felt that he had "no other choice" but to go to the Emergency Department.

Ms. F. came to Emergency concerned about an increase in pain and a burning sensation under a cast on her right ankle. She had apparently slipped three weeks before, was brought to the Hospital by ambulance, and had a cast applied. She had been having difficulty sleeping the last few nights and wanted to know why her ankle was hurting so much. The rationale for Ms. F.'s decision was also based on previous experience having had a cast and not experiencing such pain before. The decision to come to the Hospital was based primarily on the fact that her cast had been applied at this Hospital and it was convenient, due to its close proximity to her home in the inner city.

Mrs. G. came to Emergency requesting a dressing change for a burn that she had the previous afternoon. Mrs. G. was Spanish-speaking and required translation by her husband. Both Mr. and Mrs. G. were very pleased with the rapid treatment provided to them the day before her current visit. The dressing had become soiled and Mrs. G. requested a dressing change. She also thought it would be beneficial to have her burn "looked at" again. The choice of hospital was based on the proximity to Mrs. G.'s home and the fact that she had initially been seen for her burn at that facility.

The reason Mr. H. came to the hospital was for relief of lower abdominal pain which was found later to be an infection of the testicles. He had been experiencing some discomfort for two days, however he felt that he should be examined by a physician when his pain became more severe. Since it was a weekend, Mr. H. decided to come to Emergency. He chose the facility since it was where his family physician had admitting privileges.

Mrs. I. arrived in the Emergency Department due to pain in her shoulder and difficulty moving her arm. She had been picking something off a lower shelf while playing with her grandchildren, when a heavy object fell on her shoulder from a counter. Mrs. I.'s shoulder had been sore for two days prior to her feeling she should have a physician look at it since it wasn't getting any better and she was having difficulty sleeping as a result of

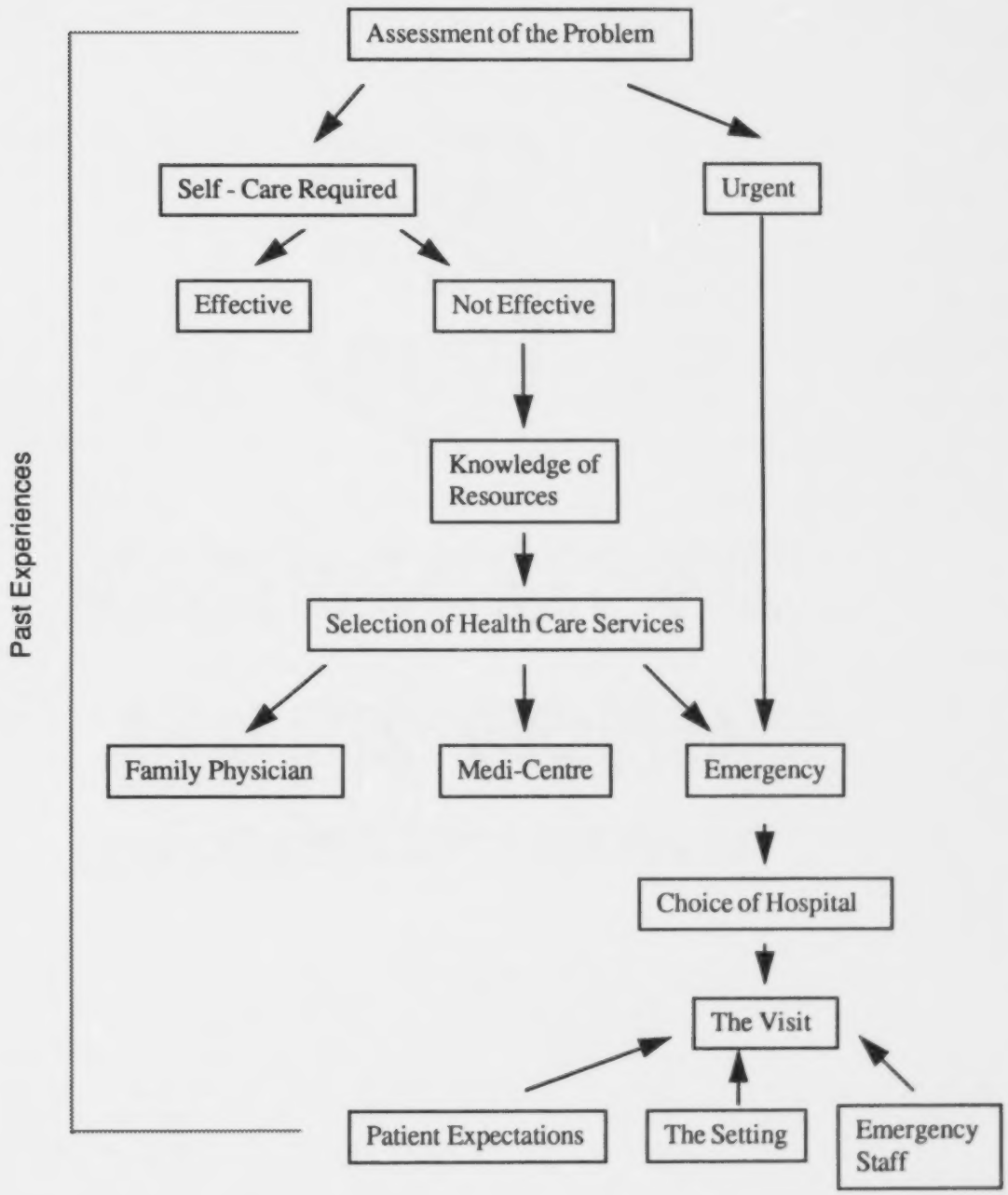
the pain. Since Mrs. I. wanted to be examined as soon as possible, she decided to come to Emergency. The choice of facility was based on the admitting privileges of her family physician, as well as, the proximity to her home.

The Experience of the Nonurgent Patient

Throughout the interviews with nonurgent patients, a process of decision-making became evident (See Figure 1). Following assessment of their problems, self-care methods were attempted by the patients. When these measures were not effective, patients would then go through a selection process to determine which health care service would be most appropriate for them. Knowledge of resources and past experiences were critical factors in the patients' decisions to seek medical care from either a family physician, Medi-Centre, or an Emergency Department. When the Emergency Department was selected as the appropriate alternative, the individuals then had to choose which Emergency Department would be suitable for them. During the "visit" to Emergency, experiences of the nonurgent patients were influenced by the patient's expectations, by the physical setting, as well as by the staff. To facilitate understanding of the experience of the nonurgent patient in the Emergency Department, each step in the decision-making process is described.

Figure 4.1

Decision-making Model of Patients



The Experience of the Nonurgent Patient

Assessment of the Problem

Once the informants identified a health problem, generally they would assess the concern and attempt to care for it themselves at home. Various remedies and home treatments had been tried by 5 out of the 9 informants. Self-care efforts included such things as "trying to talk the pain away" and "focusing natural body opiates to central points to increase relief of pain"; self-medication at home with either prescribed or over-the-counter medications; or simply trying to "wait it out" with the hope that the problem would subside. The remaining four informants sought treatment due to a change in their condition and the belief that medical care was required, that is, a patient with burn two days earlier who chose to come back to Emergency for a dressing change; an individual in a minor hockey accident who wanted to know as soon as possible how serious his injury was; a patient with a cast who began to experience an increase and difference in the type of pain; and a patient whose prescription had run out that day.

When identifying the seriousness of the problem, the decision to seek medical attention was influenced by an increase in the pain, or a change in the type of pain being experienced, a lack of effectiveness of home remedies, or a need to know what exactly was wrong. Following the informants' assessment of their illness or health concern, they arrived at the decision that they required medical assistance. The next step in the process was to select "where" they should go to obtain the care.

Knowledge of Resources

Selection of Health Care Service

Nonurgent patients' selection of appropriate health care service was based primarily on their knowledge of resources as well as past experiences. Based on these factors, patients chose to seek medical care from either their family physician, a Medi-Centre, or an Emergency Department.

Family Physician

Several factors influenced patients' selection of a family physician and when they felt it was appropriate to utilize her or his services. Seven out of nine nonurgent patients stated they had a family physician who they saw "often". Generally patients seemed to utilize the care of their family physician "when there was a problem". Visits ranged from approximately once a month, for an individual with diabetes, to once every two years. The length of time patients were ill and had not, in their perception, become better was significant in their decision to seek medical assistance. As one person commented, "I think it was three days and I said that's enough so I phoned for an appointment".

The family physician was also important to some of the patients in assisting them to decide, or deciding for them, which health care resource to utilize. "We've had him (family physician) for a long time...the whole family does actually. We'll go there (physician's office) and if I need to go to Emergency, he'll tell me". "He sees my daughter, so he's really a family Doctor ... you know he says he'll meet us in the Emergency Department, we go there". This was also true for another patient who decided where to

be seen by contacting her family physician first, "...phone him (family physician) and he tells us what to do, come in or whatever...".

The option to seek health care through a family physician was limited by the physician's office hours and the length of time before patients were able to make an appointment. The availability of the physician in the office was also influenced by such factors as day of the week; the doctor's vacation; and when their physician would be available in the office due to a need to be with another patient in the hospital. The length of time it took to obtain an appointment with the family physician was a very strong factor in determining whether the patient could/would wait, or would choose to seek an alternative source of health care. "Once you get in its good but its just that waiting...It takes forever just to see him. Even if you have an appointment, you gotta wait at least an hour before you see him. If you don't have an appointment you get at least a good couple hours".

The decision to utilize a family physician was based on nonurgent patients' perceptions of the seriousness of the illness. If they perceived that their care may require specialists or advanced technological equipment and procedures, the Emergency Department appeared to be the optimal choice. This was the case for a young lady who normally would see her own family physician, but after assessing the severity of her illness decided to come to Emergency. "I see my family Doctor for all kinds of things, but I don't think I ever felt so sick in my life".

Two patients, however, were quite quick to point out that they did not have a family physician because they were healthy. One patient commented, "No, I don't have enough reason to (have a family physician)...for the most part...I'm in fairly good shape...I don't have any pains, illnesses or weaknesses aside from a common cold now and again". This same individual, however, still believed in maintaining routine, consistent medical care for his children.

Distance away from the physician's office was a critical factor in the decision to see a family physician. This was evident in a nonurgent patient who wanted to see a physician on the "same day" his prescription for Dilantin ran out. He had moved to a different area of the city and found it too time-consuming to travel by public transportation, since he did not own his own vehicle. He had not considered changing to a physician whose office was closer to his home. There was a "sense of loyalty and trust" in the physician related to positive interactions during a critical time in the informant's epilepsy.

Transportation was also an issue with a patient who was on social assistance when she was deciding whether to see her family physician. She expressed a concern regarding the process of arranging for transportation to health care resources. Apparently, if at all possible, her social worker emphasized that she was to go to doctors' appointments by bus. If she really did not feel capable of taking a bus, obtaining approval to go by cab could be difficult. To decrease the possible conflict that may arise in trying to convince her social worker of the need to take a cab, it was easier to obtain authorization to take a cab to an Emergency department. It was also necessary to "book" a cab for doctors' appointments approximately two days in advance which could result in difficulty if the patient phoned her family physician and got an appointment on that same day. The patient was quick to point out that it was quite easy to obtain authorization for an ambulance to take her to an Emergency department if she needed to be seen by a physician immediately.

There was evidence that utilization of health care services during childhood also influenced whether patients sought the care of a "family physician". "Dad was like the rest of us, he didn't ever go to the hospital ... except when mom was giving birth to one of the many (11) children in the family"; "I really don't even have ... a medical doctor that I see". "I don't like to abuse the system if I'm functioning okay and you know I've got only a headache ... I don't mind just taking an aspirin and relieving my own problem, but I don't... go to the doctor and encumber the system". This same patient expressed a concern

regarding "abuse" of the health care system. His place of employment required a visit to a physician to certify whether he was ill which appeared to irritate the patient for two reasons: first, by doubting the validity of a person's perception of his/her illness, and second, by providing added "business" for physicians. "So that doctor has to ...certify that they (the employees) were sick for that day or three days prior to that. I don't think that's right. A person's word ... should be good enough but I mean this is one government agency forcing another to do business almost".

The decision to utilize a family physician was an alternative for seven out of the nine nonurgent patients. Patients generally sought care from their family physician when they were concerned about an illness or problem. Factors which acted as deterrents to access included distance away from the physician, length of time it took to get an appointment, office hours, vacations, time to obtain results, and the limited diagnostic capabilities of the family physician's office. Utilization of health care services during childhood also influenced patients' decisions to see a family physician. Those patients who had an established family physician expressed a loyalty and trust in their capabilities. For these patients in particular, the family physician at times assisted in the decision of appropriate health care services.

Medi-Centres

When it was discussed whether the nonurgent patients had considered a Medi-Centre as an alternative, four out of the nine patients interviewed had not considered the Medi-Centre as a viable option. Two of the remaining five patients promptly asked "What's a Medi-Centre?". Upon further discussion, one of these patients realized that she was regularly attending a clinic, similar to a Medi-Centre, in the inner city, not only for

medical care, but as well, for educational sessions such as those on Abuse and Foot care, (since she was a diabetic).

Four of the nine nonurgent patients had utilized Medi-Centres in the past as a source of health care. Patients appeared to go to a Medi-Centre if they "knew what was wrong" with them and perceived their illness as not severe, yet requiring medical attention, that is, "...for colds and flues, sprained ankles, broken toes...". "It depends if it's something you know"; "...if it's a cat bite or something like that, or a sliver, or a cold, well you go to the Medi-Centres...". "Some things you feel are not very serious but need medical attention". Based on the patients' assessment of their health problem, some patients believed that if a person felt they were quite ill, a Medi-Centre was not an appropriate source of care: "not much use going (to a Medi-Center)...if you feel real bad because they're going to send you there (Emergency Department) anyways".

At times, patients decided to seek care at a Medi-Centre only after trying to get an appointment with their family physician. If this was not possible, they would attempt to then go to a Medi-Centre: "I would take them (family members) to her (the patients) doctor, if her doctor is busy, I take her to a Medical Centre (Medi-Centre). For some patients, seeking medical care through a Medi-Centre was not perceived as a viable option. When these patients would attempt to see their own family physician and were unable to get in to see the physician within an acceptable period of time, these patients perceived the Emergency Department as their only recourse. They felt that..."because we have a family doctor ...(and) have never thought of a Medi-Centre -- either it's Emergency or our doctor".

Patients' perceptions as to the "quality" of medical care was also influential in their decision not to utilize Medi-Centres as an alternative. "I consider a Medi-Centre is like a bandaid solution...they're dispensing little bandaids, whatever it is that they call it, which in one sense they address the immediate need,...but have no idea of the long term".

Although this nonurgent patient had a family doctor, it seemed he rarely saw him, other than with issues regarding his epilepsy, in which case consistency of care was important to him. "I don't consider them inferior or anything like that ... I consider that being in touch with your neurologist or your GP (General Practitioner), they know a lot more about you".

The time of day as well as the day of the week, when an individual wanted to be seen by a physician were critical factors in most patients' decisions to go to a Medi-Centre, since the usual hours of operation of Medi-Centres are from 0800 - 2300 hours. "It (Medi-Centre) was the only place that was open on Sunday and I didn't want to go to the hospital. It would be faster to go through the clinic than to the hospital". If the patients wanted to see a physician between the hours of 2300 and 0800, a Medi-Centre was not a viable option. "I went to a Medi-Centre and I thought they could treat me just as well almost,... but it was closed so I went to the closest hospital"; "There's nothing else open so I have no other alternative".

For those patients who appeared to utilize Medi-Centres, they generally went to the Medi-Centre closest to their home or work. "There's one right in the immediate vicinity maybe ten ... well five minutes away,... and there's one coming from work, should anything happen. So there's a couple that I would go to but the one that's nearest us ... is the one I use most frequently". The location of the nearest Medi-Centre was not always known to the patient and seemed to prevent the use of such facilities. "I am not always sure where the nearest Medi-Centre is".

A concern regarding the length of time to be seen by a physician at a Medi-Centre was also expressed. There was a perception that there was a "greater degree of bureaucracy with Medi-Centres". The admitting process was viewed as longer in a Medi-Centre. A "long form " had to be completed, the patient had to "produce a card", as well as, some "identification". "It takes forever to see him (physician in a Medi-Centre),...even

if you have an appointment you have to wait at least an hour before you see him". "If you don't have an appointment it takes about two hours". "They're just too busy...the care there is good once you get in ...but it's just the waiting".

During the interviews, it became evident that the decision to utilize a Medi-Centre arose out of "convenience", since it was often easier to access a physician in a Medi-Centre than to arrange an appointment with a family physician. A strong factor in the decision to go to a Medi-Centre, therefore, was whether the patient "knew" both what was wrong with him/her, and what they "needed to get" from the physician. "Know what's wrong, you just want it fixed or you want to get something you need...". "I'm not looking for a diagnosis, I know what I have, I'm going to go in, explain my symptoms and be reasonably sure what I'm going to come out with". Medi-Centres were also utilized by some patients as a second choice, once they discovered that their family physician was not available.

Not all patients were knowledgeable regarding Medi-Centres as a viable alternative for health care. Factors which hindered the use of a Medi-Centre were negative past experiences, lack of knowledge regarding the location of the nearest Medi-Centre, length of time necessary to wait to see a physician, and hours of operation. When patients assessed their problem as serious and felt no other resources were available to them, Medi-Centres were not perceived as an alternative.

Emergency Department

The Emergency Department was definitely perceived by all the nonurgent patients interviewed to be the "best choice" when selecting a source of health care if they had exhausted their usual home remedies and resources, and visiting their family doctor or a Medi-Centre were not perceived as viable options. "If you have problems on the weekend

that's the only place that you can go", "I can't see my own doctor, my doctor's not available, so Emerg. is the only place to go". "I don't believe I'm an emergency case but this is the only place at 2:30 in the morning that's available and so I have to come to a hospital. Otherwise...I would go to a Medi-Centre and not encumber the tax system...".

The decision to go to an Emergency was influenced by knowledge of "what was wrong" with them, or by a "change" in an existing condition. Patients examined the health care resources available to them based on how severe they viewed their illness. When it was perceived as serious, the Emergency Department was viewed as the only and best alternative. This was evident in a young female who came back to Emergency for the second time in two and a half days because "she had never felt so sick in her life". She appeared exhausted and extremely concerned about how unwell she was feeling. Other informants commented, "...if it's an Emergency and if it's something that has to be taken care of right away then it's easier to get more attention and be quicker at the hospital rather than at the doctor". "If it's serious then you go to the hospital". "Emergency is the last resort, like we were, when you know you're so sick...there's no use going to see a doctor. Then that's where we go, to Emergency. If it's serious, then you go to the hospital".

There was a close association by the patient with the "seriousness of the illness" and the necessity to have quick access to diagnostic tests and their results. This decision to go to Emergency was also based on the belief that should the use of advanced technological procedures or equipment, be required, Emergency was "the" choice. The patients interviewed felt that only in the Emergency Department would they be able to find out much more quickly, what was wrong with them. Unlike a visit to a physicians' office or a Medi-Centre, all their "tests" could be done in the Emergency and the results obtained most expediently. "There's not much use going (to the physician's office) if you feel real bad, not much use going to the Medi-Centre, because they're going to send you there (to

the Emergency Department) anyway". This "quick" type of service appeared to be a great advantage to patients who come into the Emergency Department concerned that "something was really wrong with them" or that "something had changed" regarding an existing condition. The speed in gaining information regarding their illness was comforting to concerned and worried patients.

The Emergency Department was also perceived by patients to be a quick method of obtaining a referral to a "specialist". "I fully expected just to get a referral (in Emergency) to go to my doctor. I phoned him right before going to the Emergency and he's a specialist. I couldn't see him right off the bat, therefore I didn't have complete access to the specialist right away...so the hospital was the place,...like an inbetween guy". From this example, it appears that when the health care system does not work as effectively or efficiently as patients wish, they will seek other avenues by which to achieve their goals.

Convenience was based on the patients' perception of what was the "easiest and fastest". Expedient care in the Emergency department was a strong theme in patients' description of their selection process of health services. "...I haven't got time to go to the doctor's so...I'll just go to the hospital and see what's going on there". "I wanted this (the prescription) refilled that day and who refilled it is immaterial to me, just as long as I get a signature and it's refilled". The knowledge that all Emergency Departments were open 24 hours every day and staffed with physicians, prompted many nonurgent patients to seek care at the nearest hospital. "Emergency is good at night". "I did try a Medi-Centre but it was closed so I decided to go to the ... closest hospital I know of. So I went there, ... I was there before so I considered that they were pretty good". "I'll never go to Emergency unless it's the weekend...and I can't get a hold of my doctor, that's the only time I will go to Emergency". One patient summarized these views when he commented Emergency is available when "nothing else is open". This patient's perception of the busyness of the

Emergency Department at nights also influenced his decision to go to Emergency. "I have no other alternative and they're down probably on manpower in the evenings or morning shifts and I'm sure maybe don't have a lot to do in some instances". Convenience also referred to the accessibility of the Emergency department. Even though a number of patients stated they did not know where the nearest Medi-Centre was, they were all familiar with the location of the nearest hospital. "Sometimes, some people need help, and I can take them right there (to the Emergency Department) and I must know where it is". This made access not only "easier" but "faster". "My doctor's in (a distant area of the city)... so I thought that was out of the question ... Time was of importance because I wanted to get my pills. I wanted to get the problem resolved that day. Phone calls and arranging doctor's appointments, they result in ...a long time to get it". An important factor was also "when" it was convenient for the patient to have the time to see a physician. "I could have waited until tomorrow morning but I think...If I get treated now, I don't have to wake up tomorrow morning. I can just relax and I know I'm taken care of and I can go home and take a shower tonight and just relax tomorrow".

Two of the patients viewed the Emergency department as an access to their family physician. If they were unable to "quickly" arrange for an appointment with their family physician, they would either arrange to see their own physician in Emergency, or the physician would suggest that they go to the Emergency and the physician would "arrange to see (the patient) there". "I would normally call my doctor and whatever he will suggest I will do. If he wants me to come into the office I go, if he says he'll meet me in the Emergency that's what I do". Although the inclusion criteria of nonurgent patients in this study required a "self-initiated" visit, it is understandable that past experiences such as these would influence patients' decisions and ultimately the selection of health care services. If patients did not have a family physician, it was generally perceived as inconvenient for them to initiate the process of trying to find an appropriate physician.

An inherent belief by the patients that they would receive a very high standard of care in the Emergency department was also prevalent in discussions concerning the selection of health care services. The feeling that the knowledge and skills of Emergency staff were of high calibre also facilitated the decision to utilize the Emergency department. "She really feels more comfortable at the hospital".

Patients' beliefs that the "care" in Emergency departments was delivered expediently was a factor in the decision-making process. Emergency was viewed as the "only" alternative for one patient who wanted medical care by the "quickest and easiest road". Patients seek medical care, diagnosis and/or treatment, quickly, to "get the problem resolved that day". "I go to an Emergency cause I'm concerned or I know what's wrong with me and what I have isn't dealing with it and it's now that I want it dealt with". "Emergency is something you didn't expect and you're supposed to move fast". "In Emergency, they are supposed to be fast with the attention". Since five out of nine nonurgent patients were experiencing pain in varying degrees of intensity upon admission to the Emergency department, and if the premise that Emergency care was "fast" for all patients regardless of their priority was a prevalent belief, it was therefore understandable why patients would decide to seek medical attention through an Emergency department. Even when one of the patients acknowledged that she "knows and expects to wait because others (patients) are more ill", it was apparent that she still believed that she would be seen by a physician in the Emergency department much more quickly than by her own family physician (who was on vacation).

Selection of an Emergency Department as the most appropriate resource for medical assistance was largely based on convenience, ease of access, rapid availability of specialists, diagnostic tests and results, and quick service. Patients were all knowledgeable as to the location of the nearest hospital. Health care in Emergency was

perceived to be "the best", and the only alternative, serving as a "last resort" when patients did not know what was wrong with them and viewed their illness as serious.

Past Experiences

Patients' past experiences with health care services strongly influenced their decision whether they would seek medical care from a family physician in the office, at a Medi-Centre, or in an Emergency department. Not only was the knowledge and awareness of health care sources a critical factor in the decision-making process, as well, past experiences with these services were a strong influence.

If individuals did not have a family physician and were concerned about a sudden illness, or minor injury, the belief that they wanted to "see someone (a physician) as soon as possible" would conceivably act as a deterrent to "finding" a physician through other sources. All of the nonurgent patients interviewed, with the exception of one middle-aged man, stated that they had a "family physician". Through the experiences with their family physicians, patients were aware of office hours and, generally, how quickly they would be able to make an appointment to see their own physician. If the patient had arranged an appointment in the past and was then sent on for "tests" to another facility or to the Emergency department, this confirmed for the patient that if they felt there would be a need for lab tests, or procedures, the fastest way to ensure getting them done and obtaining the results was through the use of an Emergency.

Individuals who had never utilized a Medi-Centre in the past were unlikely to do so in order to seek medical care either due to a belief that Medi-Centres acted like "bandaid solutions" or because they were not aware of the location of the nearest Medi-Centre. If the experience with the Medi-Centre was not a positive one, individuals would

then be unlikely to attempt another such visit particularly if they were concerned about an "illness" and felt they wanted to be seen "right away". It was evident that if the perception of the patient was that it took too long to go through the admission process the last time they visited a Medi-Centre, this experience influenced their decision as well.

Faith of the patients in their physicians' capabilities also influenced their selection of health care resources. If the physician was able to help them in the past, they would much sooner see their own physician if at all possible. For example, one middle-aged lady who had been treated for cervical cancer ten years earlier was strongly committed to the belief that she should always try to go to her own family physician first. However, three of the nonurgent patients discussed occasions in the past, when they realized a family physician had made an error. This resulted in the belief that the health care system was not "infallible"; and they felt the need to question the actions of the health care team. An older female patient related an experience which occurred when her children were very young when she was devastated to be told that her young daughter had diabetes and required immediate hospitalization. Following admission into the hospital, an intern later discovered that the diabetes-like symptoms were in fact a reaction to baby aspirin. This incident not only angered her and her husband, but left a painful memory as well as a sense of doubt in the capabilities of a family physician. A sense of anger was evident as a middle aged patient discussed her difficulties with a fractured ankle. She had come to Emergency to find out why she had begun to experience an increase and change in the type of pain from her ankle. "Then they x-rayed (my ankle). After that they said that the ankle wasn't set properly the first time, that's why there's so much arthritis in it". Another patient, after having been told that he had a fractured rib, found out otherwise three months later. This experience later affected his confidence in physicians. "My perception of the medical profession (is), they're very helpful but they're not always right. I was told once by a doctor that I would never walk again, I would never complete high school". Since this

individual had achieved these goals he, as a result, questioned physician's judgement at times.

Childhood experiences with health care services were influential in the patient's decision regarding when and where to seek health care services. "We grew up on a farming background. The only thing that we really ... went to hospital for was if we slipped on a nail in the farmyard. We would go in for a Tetanus shot and the schools would occasionally be visited by a dentist and they'd have dental work done. There wasn't a whole lot but most children when they're growing up are fairly healthy". If as a child, a family physician was utilized, this influenced whether as an adult, a family physician would be sought. This was apparent in one of the patients who felt he did not have a need for a family physician because he perceived himself as healthy. "There was a family doctor, but primarily the doctor was my mom's doctor because dad was like the rest of us, he didn't go to the hospital ... except when mom was giving birth to one of the many (11) children in the family".

Patients appeared to be influenced also by past experiences of friends and family. A neighbor's negative experience regarding a perceived long wait was brought up by one of the patients when he compared how well he was treated in the Emergency Department. He felt "fortunate" to have had a positive experience, or one of the "lucky ones" compared to that of the neighbor. "I understand I'm one of the fortunate ones (but) one of my neighbors, ... would have liked to talk to you". This provided a source of comparison by which the patients seemed to judge the experience. An experience two years ago influenced how a patient not only evaluated her visit, but also made her quite apprehensive fearing that she would have as "bad" treatment as her fiance had in an Emergency Department, in another city. Two years ago she had accompanied her fiance with a fractured ankle to a hospital in another city, where she felt he waited too long to be cared for and was not provided any pain relief. "Oh, it was so frustrating and they kept saying,

'you know, well it won't be much longer, it won't be much longer', but ... they just left him....No pain killers, nothing. Maybe they forgot about him...but I don't know, they couldn't because I kept asking...How much longer is this gonna take?'...They just ignored us. I hated to see him sitting there suffering. The whole experience was very frustrating and it was painful to watch him in so much pain". This experience seemed to frighten her when weeks before this present visit, she went into the Emergency Department with a fractured wrist. Her anxieties regarding how well she would be cared for with the fracture, she believed, stemmed from the negative experience with her fiance two years earlier. Fortunately, however, the experience with the fracture was a very positive one for her. "When I came in with my wrist, they took me immediately and made sure that I was comfortable. They gave me a shot immediately and I didn't wait any length of time...They really saw to me just right away and did not leave me at all". Nonurgent patients also chose to come to the Emergency Department as the result of having been influenced by positive experiences in the past when they brought in their children or grandchildren. "...Everytime we come through here they (the Emergency staff) take them (the grandchildren) in right away. They see me right away and they took the baby right away".

Personal past experiences with the health care services influenced one patient's confidence regarding the efficiency and effectiveness of the Emergency Department.

> I was more in pain and I was totally at the whim of whatever the doctors and dentists suggested. I had total confidence in them that they would make the best decisions and relieve me of any pain I had. On this particular occasion, I haven't yet seen the doctor, I just got here and again ... I know that (the pain) will be relieved fairly easily.

Past experiences with a different source of health care in another country (U.S.), also influenced not only how a patient evaluated their treatment, but also the decision to seek medical care and the selection of the appropriate source.

> We were in the south U.S. and having doctors is a little different there, where you just don't go to the Emergency like you would here in Canada. I would have to sit all weekend with this (an itchy rash) until I could see my doctor. I would see a doctor in his office and we would have to be referred to the Emergency from the doctor. They have to call ahead of time and let the Emergency know that you're coming so you're expected. You can't just walk in and say 'Here I am, like I did today here'.

The effect of living under a different type of health care system had influenced this lady to the point that she stated she always would try to go to her family physician first if she required medical attention. On this particular occasion, when she tried to contact her family physician and discovered he was on vacation, she decided to come to the nearest Emergency Department.

A previous experience several years ago in a different Emergency Department was very upsetting to one of the informants, who was Spanish-speaking and spoke minimal English. She felt no one even bothered to attempt to converse with her due to the language barrier. Even though this experience took place years before, it still was quite vivid in her memory and influenced her selection of health care sources. Through the assistance of her husband translating, she commented,

> There was nobody that spoke Spanish...She had to go to Emergency right away and I guess she had a lot of problems because they couldn't understand. It's really upsetting when the person (Emergency staff) just says, 'Well I don't understand'.

As a result, this previous experience made the patient believe it was important always to bring an interpreter with her on subsequent visits to an Emergency Department.

A sense of powerlessness or loss of control was expressed by three nonurgent patients regarding their experiences in coming to an Emergency Department in the past. These patients perceived that as a patient you have no power or control regarding your

care and are at the mercy of the health care providers. "I think basically because a lot of the power or judgement is beyond me". When this patient was asked who he perceived held the power, he felt it was held by those who controlled when you were to be seen (the Emergency staff). One patient believed there was a "potential for (abuse)", that for reasons other than priority, patients may be made to wait unnecessarily. Based on these experiences, the patients felt the need to become much more assertive in obtaining what they viewed as good care and when selecting various sources of health care.

Previous experience of having come to Emergency and being "impressed" with the care served to reinforce the effective and efficient "service" that patients expect. "I had fast treatment when I came into this Emergency a few weeks ago with a broken wrist". "Fast" treatment in the past seemed to be closely associated with "good care". The type of reception the patient received from the staff in the Emergency department was very important. "If I have something to deal with that needs attention right away, I just come to the Emergency department because I don't feel any negative impact ... here". "The doctors and nurses were very nice".

A middle-aged patient also related how a past experience over the telephone influenced his perceptions of Emergency staff. A telephone conversation with an Emergency nurse regarding his ill son, left him feeling extremely distressed and angry. He did recognize that it must be a great stress on the Emergency nurses to receive numerous phone calls for information, however, when he phoned to inquire about his son, who he felt was very ill, the Emergency nurse seemed quite abrupt and told him he was "over-reacting". By minimizing the patient's concern over his son's illness, he perceived the quality of care to be minimal.

> I can remember saying to my wife at the time, ... "Well to hell with them boy. You know I wouldn't take a dying dog in to them". As time went by I said to myself, "Dummy, why did you even take the time to phone, you should've just went.

> There's got to be nothing more frustrating than trying to deal with a ward full of Emergency patients and people phoning up to tell you their symptoms. What can you tell over the phone?"

From this experience, the individual felt he gained more insight into the difficulties of seeking medical advice over the telephone, and in the future did not call the Emergency Department to seek medical assistance, but went directly to the hospital.

One interview demonstrated how perceptions of an Emergency staff member's behavior differed between a patient and that of her boyfriend. The patient came into Emergency for the second time in two and a half days. Her perception of the behavior of the attending physician was very neutral. Her boyfriend, however, felt the behavior of the doctor was "tactless". Although he appeared to be angry with the physician's "uncaring" behavior, he also was fairly quick to excuse the behavior due to the environment of the Emergency Department.

> He kept cutting you (his girlfriend) off and was more or less... to me he wasn't being professional. His personal feelings at the time were coming through. I seen it, I was sitting right there. The way he cut you off and 'Yup, yup, yup, yup, yup', and away he went. Sure, he may be busy, but he could say 'Excuse me, I understand and I have other things to do'. To me that's what I felt but...you're the one in pain. At that time I felt that he was being a little rude, by the same token, I understood, he's got a lot of things on his mind, he's got an awful lot of people coming through here, everything from stubbed toes to you know, God knows what.

The patient's boyfriend seemed to feel that the physician's behavior was "uncaring". The boyfriend's only frame of reference was to compare his treatment in the past with this situation when he accompanied his girlfriend into Emergency. "The only Emergency situations I've been in, they've (the Emergency staff) been really good to me. They had a

lot of care". Caring, within the context of this individual, represented attentiveness and concern for the patient. Since this individual often sought direction in the selection of health services from this significant other (boyfriend), his past experiences in accompanying the patient to Emergency could be influential in the patient's future choice of health care alternatives.

The influence of past experiences in obtaining health care had a significant impact on the decision as to when and where to seek medical services. These experiences reflected not only those on a personal level, but also the experiences of the nonurgent patients' significant others. Patients' decisions regarding the selection of health care services and satisfaction with care was largely influenced by the patients' past experiences.

Choice of Hospital

Once the individual had selected the Emergency department as the appropriate health care service to deal with their concern, the question of "Which Emergency department?" was important to them. Factors which the nonurgent patients identified as having influenced their decision in choosing a hospital were convenience, proximity of the hospital to their home, previous utilization of the hospital, admitting privileges of their family physician, and the hospital's reputation.

The location of the hospital was an important consideration in the selection of an Emergency Department. "I came here just because of proximity but I did prefer to go to (another hospital), but I just wanted to get this over with very quickly". "It was the closest hospital". "I went to a Medi-Centre and I thought they could treat me just as well almost but it was closed so the next closest hospital (was this one)". Transportation resources available to the patient affected the choice of hospital. For one patient on Social Assistance transportation was a major consideration in her decision. "I live within

minutes"; "I'm a block away"; "I come here because its closer"; "I believe this one is the closest to our house...and that's very important". Although the proximity of the hospital to where the patient lived was a critical factor in the selection of the appropriate hospital, the location of the hospital also presented a concern for two of the patients. The fact that the hospital they chose to go to was located within the inner city, presented a safety concern. However, this was outweighed by the patients' perceived need to be seen by a physician as quickly as possible.

Two patients felt that proximity was not a factor to be considered at all in their decision. The most important point they considered was where their family physician had admitting privileges, "Wherever the doctor admits, that's where you go".

A Native patient who was on Social Assistance and lived within the inner city, said she normally utilized another facility because it was "the only place Social Services will pay for Emergency". "If I have to go to Emergency, I have to go to the (a different) Hospital. I don't know, they (Social Services) won't pay for a cab to (this) Hospital." This visit to Emergency was apparently validated by Social Services since the patient had her cast applied at the hospital participating in the study, when she was taken by ambulance with a fractured ankle five weeks earlier. It was evident that this patient's decision regarding which hospital she would go to was based primarily on what would be paid for by Social Services.

Previous utilization of the hospital and the availability of the patients' past medical records was important to patients in their selection of a hospital, "...they've got all that information on me right there (at the hospital where her family physician admits)". This belief was also associated with the impression by one of the patients that the care would be faster as a result of easier access to their previous records. If patients had utilized a particular hospital in the past or their family and/or significant others had been treated there before, this influenced the patients' decision. If patients had already been seen

previously for a particular illness which had not improved, they would subsequently come back to that hospital again for further treatment. Two middle-aged patients emphasized the fact that they had chosen to utilize the same hospital since the birth of their children several years ago. "Because my daughter was here, my grandchildren were born in this hospital, my fiance had a gallbladder here, in November,... so we've had all the family come through here". "I have been going to (this) hospital since the twins were born".

The perceived reputation of the hospital was influential in deciding to which hospital the patient would go. Another facility was perceived by one of the patients as "state of the art", and as a leader in the health field. "...My choice would have been (a different) hospital because I think they're just a wonderful hospital, probably one of the best in Canada... Leaders in the health industry". However, this hospital was closer to his home and he "just wanted to get this one over with very quickly". Based on his comments, it was clear that if the patient had felt his injury required specialization and advanced technology, he would have chosen another hospital.

Experiences with hospital staff both as an Emergency patient and as an inpatient seemed to affect the individual's impression, either positively or negatively, regarding the level of care provided to patients in that particular hospital, and decisions as to which facility to seek health care from in the future. One elderly gentleman's account of an extremely embarrassing and upsetting experience as an Emergency patient when he was very ill, made him prepared to "stand up for himself" the "next time" he felt he was experiencing "rough" or rude treatment from an Emergency nurse. He commented, "I had to go to the bathroom...I waited and waited...I just dirtied myself and then she (the nurse) sent me to the bathroom. She said, 'Can't you take your clothes off? Can't you do this?'. The way she (the nurse) talked to me, that's the bad part. I remembered that she was rough". This same individual and his wife also added that they did, however, inadvertently overhear the nurses speak with another patient who seemed to be in for psychiatric

problems. A member of the staff was "talking to him you know and he took the time and he talked and he talked and then he said, T've got nothing to live for'. You know and I thought he was really using compassion to him to start thinking different. They (the Emergency staff) come across all kinds of people, so sometimes you can't blame them for being a little rude". When the patient was asked how the staffs' behavior affected him he was quick to point out, "It hurts".

Several patients expressed a very forgiving patience with what they described as "grouchy" or "tactless" behavior on the part of the staff. "Yeah, there's the odd one that will be a grouch, but not everyone...any hospital has that". One of the patients discussed not only how he felt when a staff member was "irritable", but went on further to rationalize why he felt the staff might react in this manner and that he chose "not to pay attention" and not to "bother" them (the staff) when he sensed this behavior. "Oh, they're (the staff) pretty good. There's the odd one that's not as good. It all depends on how long they've been here I guess. If they put in long hours that day they get pretty..., sometimes you find one that's irritable but other than that, they're pretty good. They're nice like when you ask them something. They answer". A similar type of avoidance of confrontation was expressed by a middle-aged Native female who related an experience when she reacted to the Emergency staff's behavior by walking out of the Department and going to another hospital. "This woman, oh the bitch was just shooting questions at me like a Judge. 'Just forget it,' I said, and just got up and I walked out of there. When I was walking out she hollered at us, 'Come back!', and I just pretended I didn't even listen. I had my daughter drive us downtown and said, 'To hell with it. Take us to another one (hospital)'. This patient's reaction to what she perceived to be abrupt responses or behavior on the part of the hospital staff was that she "feels like walking right back out (of the Emergency Department)"; "I don't even want to stay when they do that"; "I am not sitting here taking this because I don't think I deserve it". These experiences ultimately served to influence

the patient's perception of the quality of care provided in that particular facility and, therefore served to influence the patient's decision in the future when faced with the need to choose a hospital for medical assistance.

Safety issues also influenced how two male patients felt about their choice of hospital. They expressed concern regarding their own safety when they were walking to the parking facilities from the Emergency Department. The fact that the hospital was located in the inner city, made them a bit hesitant. "I've gotta walk to my vehicle. I don't feel safe". The other patient also identified a safety concern, regarding the distance he had to park from the Emergency entrance, as well as the fact that his foot was sore, yet he had to walk such a distance. "I'm about three blocks away and I've got a sore foot".

The choice of hospital then was influenced by factors such as convenience, proximity to home, previous utilization of the facility, admitting privileges of the family physician, and the type of care provided. Some patients' decisions were based on proximity alone. For other patients, previous experiences with the hospital, and where their family physician had admitting privileges were more important to them than proximity. These patients would travel throughout the city to utilize the hospital of their choice because these factors were significant to them and influenced their perceptions of the quality of care they would receive.

The Setting

The experiences of the nonurgent patient are influenced by the environment in which they seek care. A description of the setting, which includes the physical environment, nursing organization of the Emergency Department, and patient flow is therefore necessary to promote further understanding of the experiences of nonurgent patients.

The hospital where the study was undertaken was approximately a 1,000 bed facility in Western Canada situated in an inner city core. The Emergency Department was built in the early 1960s to accommodate 30,000 patients per year. The numbers of Emergency patients, however, has risen to approximately 78,000 - 80,000 per year without any renovations to support this substantial increase.

To facilitate an understanding of the environment within which the study was conducted a description of the Emergency Department will follow. The description of the setting will include the physical environment, an organizational review, as well as the functional utilization of the Department.

The Physical Environment

The Emergency Department is located in the basement of the hospital. The registration area and waiting room are shared by all Emergency patients, Outpatients, and patients being admitted as inpatients. The main access to the Department is through the Emergency entrance which is situated between Patient Registration and the Emergency waiting room. Subsequently, all ambulances enter the Department through this entrance and must proceed through the waiting room to the main triage desk of Emergency, in full view of all individuals seated in this area. Patients who are coming to Emergency to be seen by their own family physician also follow the same process in Emergency and wait until their physician comes to the Department to be taken into an examination room.

Physically, the Emergency Department is divided into four main areas, the main triage desk, Exam side, Dressing side, and a four-bed Detoxification room. Each area is staffed by Emergency nurses and/or support staff and is the responsibility of the nurse in charge.

The main triage desk is the central nucleus or focus of Emergency. Patients who have completed their chart at Patient Registration come to the Emergency desk and are directed to either a seat in the Emergency waiting room by the nurse in charge, or a nurse from the unit is called to take the patient into a treatment area. All communication is centralized through the triage desk through an intercom system. All orders and requests for assistance are called out to the main desk. The nurse in charge also utilizes this form of communication to converse with the Emergency staff, Patients Registration, and Laboratory. All hospital personnel such as physicians, Operating Room porters, as well as patients, family and Ambulance personnel all access information via the nurse at the main desk. Telephone calls concerning patients from physicians, family, referring institutions, and requests for health information from the public are also received at this main desk. It is not uncommon for there to be between three to twelve, or more individuals at the desk at any given time.

Physicians also utilize the side of the desk for charting, filing the charts of patients they are currently caring for, and talking about patients with their peers or other staff members. All requisitions and lab work accumulate at this desk prior to its delivery to the lab. The nurse in charge maintains a portion of each patient's chart at this desk as a "control" copy, where she makes notations as to the prioritization of patients, documentation of orders received on each patient, and as a continuous method of monitoring patient flow.

Behind the desk is the main medication and narcotic area for the Department, as well as a dictating room utilized by all physicians working in the Department, or those coming to see a patient on consult. This room also contains a xerox machine, additional telephone lines, a computer terminal to access laboratory results, resource textbooks, and two filing cabinets, one containing special small equipment.

Exam side of Emergency consists of six separate cubicles which have two methods of access: through doors from the hallway, as well as, from the back via curtains that are drawn when a patient is occupying the examination room. Behind these examination rooms is a separate corridor for the Emergency staff where additional supplies are kept and it accommodates access to a central utility area between the third and fourth examination rooms.

Exam side is primarily for patients with Eye, Ears, Nose and Throat Emergencies, Gynecological concerns, psychiatric illnesses, and patients with concerns who are not critically ill or who do not require constant observation. If the patient is assessed by the nurse as more seriously ill, the patient is moved to the Dressing side of Emergency. The right side of the hallway on exam side is filled with stretchers against the wall to accommodate patients either waiting to be seen, those who are too uncomfortable or ill to sit in the waiting room, ill patients waiting for results, or patients waiting for inpatient beds. At the end of the Exam side hallway is a staff lounge, an office for the Emergency physicians, and a four-bed Detoxification unit which is staffed by Emergency nurses each 12 hour shift. Patients admitted to this Detoxification area are in acute alcohol and/or drug withdrawal or those who have overdosed and require close observation and care.

Dressing side of Emergency is primarily used for resuscitation, acute or critically ill patients, such as patients with fractures, overdoses, lacerations, seizures, angina and/or myocardial infarcts. The large treatment area can accommodate 10 patients sitting and three patients on stretchers. One main resuscitation theatre is located across from the large treatment area and contains equipment for the management of trauma or cardiac patients, although all theatres could be utilized for this type of patient. When this occurs, necessary equipment is moved as needed. Two other theatres are located down the hallway and are utilized to care for Emergency patients such as those requiring sutures, overdoses, cardiac patients, and other critically ill patients. Endoscopy is located at the

furthest end of Dressing side. These two theatres are available to Emergency on evenings and nights. The hallway on Dressing side is also utilized for patients on stretchers. To the right of the Endoscopy theatres is a radiology reading room, Emergency Radiology and two plaster rooms which are used for Emergency patients, Outpatients, and Inpatients.

To accommodate for the large number of patients and limited physical space, much of the nursing care and continuous monitoring of patients is done in the hallways of Emergency. The corridor is a busy area utilized as a thoroughfare for hospital staff, patients going to Outpatient Orthopedic clinics, and visitors to the hospital.

Nursing Organization of the Emergency Department

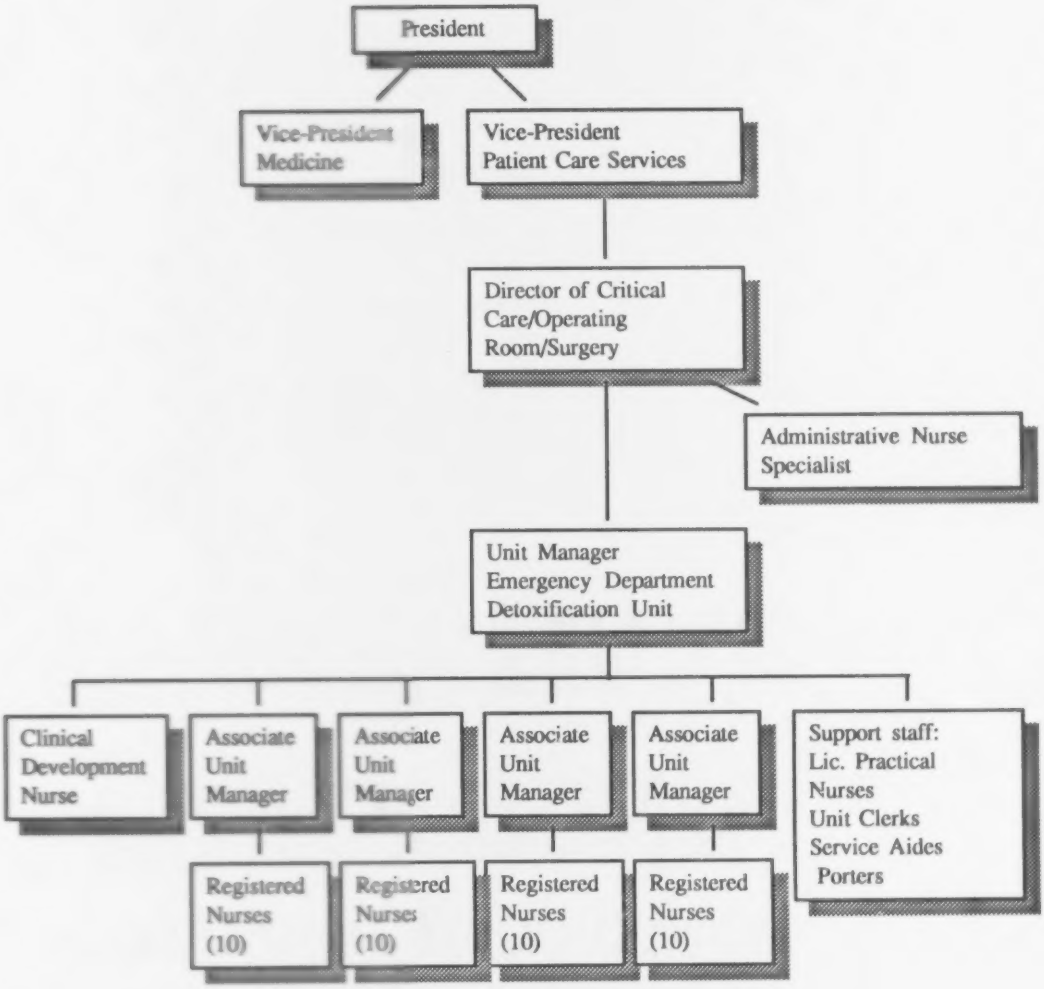
The nursing management and staffing component of the Emergency Department consists of a Director of Nursing, a Unit Manager, four Associate Unit Managers, a Clinical Development Nurse, and four nursing teams which each consist of 10 Registered Nurses. Support staff also play an integral role in the functioning of the Emergency Department: Licensed Practical Nurses, Unit Clerks, Service Aides, and Porters (Figure 4.2).

The Director of Nursing responsible for the Emergency Department has a large portfolio which includes Intensive Care, Operating Room, and the Surgical Units. The Unit Manager reports directly to the Director and is responsible for the overall administration of the Emergency. Each team of ten nurses is managed by one of the Associate Unit Managers, who works the same rotation as her team and is accountable for the quality of patient care, staffing of the team, as well as hiring and performance appraisals of the team members. The Associates primarily work at the main desk, prioritizing patient care, and directing and organizing workflow. The Registered nurses

function under the direction of both the Associate Unit Manager and the Unit Manager and are responsible for the delivery of safe patient care.

Figure 4.2

Nursing Organization of the Emergency Department



The Clinical Development Nurse is responsible for the professional development of the Emergency staff. Her role includes assisting in teaching a portion of a critical care core curriculum, classroom and clinical orientation of new staff to the Emergency Department, and ongoing continuing education through inservices. The Clinical Development Nurse works an eight hour day shift to conduct orientation and inservice education.

Licensed Practical Nurses (LPN's) work primarily in the Plaster Room, applying and removing casts, splints, Jones Bandages, and assisting in Emergency whenever possible. Often the LPN's are called upon to perform cardiopulmonary resuscitation during a cardiac arrest. One LPN is scheduled for each shift.

Unit Clerks (UC) are located at the main desk in Emergency. One Unit Clerk is on each shift and is assigned to work with the Associate Unit Manager or nurse in charge at the desk to assist in performing numerous clerical duties such as completing requisitions, answering telephone calls, paging physicians and staff over the intercom, and completing other clerical duties under the direction of the nurse in charge. Since the Unit Clerk is situated at the front desk, this individual may have the initial contact with patients in taking their Emergency charts, listening to any initial comments and information offered at this time by the patients, and either instructing the patient to wait in the waiting room, or calling a nurse to take the patient to the treatment area.

The Service Aides assist the Emergency staff by performing a large part of the cleaning and ordering of supplies. Aides dismantle trays, clean equipment, restock rooms and ensure that an adequate amount of equipment is available for the professional staff. Service Aides are not on duty during each shift, therefore, in their absence, these duties and tasks become the responsibility of the Registered nurses.

Porters in Emergency transport patients within the Department, to Radiology (Emergency Radiology, Main Radiology) and to the Nursing Units. They also deliver

specimens and equipment as required under the direction of the Associate Unit Manager or the nurse in charge. Generally each shift has a Porter on duty, however, occasionally, the staff are without a Porter either due to illness or vacation. During these shifts the RN's and LPN's assume the portering responsibilities as well.

Nine fulltime Emergency physicians also rotate eight hour shifts in the Department. These physicians are headed by a Director of Emergency Services who is ultimately responsible for the medical staff. The Emergency physicians are not employed by the Hospital, but rather are affiliated as a medical corporation whose physicians work in Emergency. Only two of the Emergency physicians, who have their fellowship in Emergency Medicine, the remaining physicians are general practitioners. The physicians also employ general practitioners to facilitate additional medical coverage. Rotating interns also work in the Department under the supervision of the Emergency physicians.

Patient Flow

Once a patient has provided the necessary information at Patient Registration and obtained a chart, it is brought to the main Emergency Desk. Based on the charge nurse's assessment, the patient may be requested to have a seat in the Emergency waiting room, or a nurse will be called to take the patient into an examination room or theatre. All patients coming to Emergency by ambulance come straight to the Emergency desk, are triaged, and sent to either Exam or Dressing side to be placed on a stretcher in an examination room or the hallway if no rooms are available.

Based on the prioritization of the patients and the availability of examination rooms, a nurse from either side then comes to pick up the patient's chart at the Emergency desk and call the patient from the waiting room. Once the patient is in the examination room, an initial assessment is conducted by a nurse, vital signs are taken, and the patient

undressed appropriately. The patient then waits in this room until a physician is available to see the patient. The nurses working in Emergency are assigned to patient care areas, not to specific patients, unless the patient is critically ill and requires constant care.

Following the examination of the patient by the physician, patients may be discharged directly, have diagnostic tests done and be required to wait either in the waiting room or hallway, or be admitted and required to wait for varying periods of time until a hospital bed becomes available. Patients admitted and waiting for hospital beds can either be transported up within the hour, or wait as long as several hours and even occasionally for one or two days for a hospital bed. The Emergency patients on either Exam or Dressing side are the responsibility of the nurses assigned to the area. Each area also has a Team Leader, a more senior, experienced Emergency nurse, whose role is the coordination of patient care in each area.

The Emergency patients and other individuals, such as family members, seated in the waiting room have full view of the main Emergency desk through a glass partition. All activities taking place at this desk are in full view of the individuals in the waiting room. The nurse in charge, is primarily responsible for monitoring the patients in the waiting room.

Expectations

Each of the informants had certain expectations of the care to be provided to them. Expectations can be categorized under two headings: the "type" or quality of care patients expected in the Emergency Department; and expectations of "how" the care was to be provided to them.

Expectations of Care in the Emergency Department

The most prevalent expectations of Emergency care were appropriate prioritization of patients as to urgency for care and rapid treatment of patients. Patients verbalized an understanding of "treating" the more acutely ill patients first. "They (Emergency staff) prioritize their cases you know and if it's not a big time Emergency, then I'm at the back of the pack and I don't mind that. They'll eventually get to me". However, discrepancies arose when the patients viewed their illness as more serious than the Emergency staff. "I just thought they (the Emergency staff) were excellent, just absolutely super...We never had to wait any amount of time". Patients generally expressed the belief that they understood and anticipated that they would have to wait for a particular period of time before they would be able to be seen by a physician in Emergency. How long they were prepared to wait was debatable. "Hopefully, I'll be home within the hour". "In Emergency I believe they are supposed to be fast with the attention". The Emergency Department was viewed by several patients to be a "quick fix", or a place where one was "treated quickly without having to wait any longer than was absolutely necessary". It was also apparent that the patients' level of discomfort affected how ill they saw themselves, thereby perceiving their needs and priority as greater than that recognized by the Emergency staff. As a consequence, patients' level of frustration and impatience increased with the length of time they had to wait to be seen by a physician.

How well patients seemed to tolerate waiting was influenced by the patients' assessment of the severity of their illness or injury and the priorities within the Emergency Department, that is, how ill other patients in the waiting room appeared as well as the busyness of the Department. "There was a wait but I wasn't on the critical list or anything

like that and I didn't mind, I expect these things. This is two o'clock in the morning, so I mean you can't have a staff of fifteen doctors on at that time, so I know there's a wait and sometimes I might have to wait longer. I mean, it wasn't a critical accident or anything". Evaluation of the patients in the waiting room was evident by one of the patients who knew she would have to wait a bit longer today because of "such a variety of sick people out there (Emergency waiting room). A lot of crutches today". Even though this patient, in particular, recognized she would have to wait longer, when the wait began to be more than an hour, she seemed quite shocked. "I've actually been waiting an hour... unbelievable".

For a number of patients, the main reason they chose to come to the Emergency Department was for the relief of pain. For those nonurgent patients this may be the rationale for their expectation of the need for rapid treatment. The perception of Emergency as a health care resource was, therefore, a source of pain relief and as a result, any length of time spent waiting to be seen by an Emergency physician was more difficult for them because of the discomfort they were experiencing.

The majority of patients believed that the physicians in Emergency would be able to find out what was wrong with them and "fix it" so that they could "get better". "I find them (Emergency staff) thorough. They check everything, they ask a lot of questions". There was a belief expressed that Emergency staff are superior, more current, and up to date than family physicians and Medi-Centres. There was a great sense of confidence in the capabilities of Emergency staff. The underlying premise upon which patients based their expectations of Emergency care was the belief that individuals who worked in an Emergency Department had to be better than staff in other areas, because of the care provided to critically ill patients. "Obviously they (Emergency staff) have more experience with ... any kind of problems. They're always dealing with problems daily".

Patients knew that by coming to Emergency, they would definitely have access to a physician and if diagnostic tests or procedures were needed, the Emergency Department was more capable of providing this service. Unlike any other health care resource, the Emergency Department would also be able to "very quickly" provide the patients with test results and, consequently, diagnose and treat them appropriately. This was a significant advantage to a number of patients who were very worried that something was seriously wrong with them. "I wanted to find out if there's anything broken, why does it hurt so much". "I'd really like to know what's wrong with me".

Associated with the quick route to Emergency physicians was the expectation that if it became necessary to see a "specialist", they were quickly accessible through the Emergency or if not, at least, within the hospital. This was of benefit to patients who realized from past experiences that the referral process at times was a lengthy one. "I expect to see a doctor and if for some reason it's ... more serious then, I'm in a position to see a specialist almost immediately. That is comforting, coming into Emergency,... if it's something the intern or someone can't handle, they usually will call the specialist".

Patients acknowledged the "waiting" for treatment to be a part of the process of seeing a physician in Emergency and seemed to evaluate the "busyness" of Emergency and compare how well they were to those they saw around them. "Today, I'm waiting but I have to expect that because there are a lot of emergencies that are in pain and suffering and I don't mind the wait. I'm expecting to wait today". Another patient commented, "Well, you see all the people ahead of you and you know they're not going to take you (in to be examined). I don't expect them to". An elderly nonurgent patient noted an inappropriate lack of patience by some patients in Emergency. He preferred to have faith and trust in the capabilities of the Emergency staff to effectively prioritize patients and he felt confident that he would be seen when it was reasonable to do so. "It doesn't bother me, I know I've got to wait and that's it. I think some people complain cause they have no

patience, they figure they have to be taken in right now, but I don't know, not the way I feel. I look at it...they'll take you as soon as they can". This patient, therefore, did not attempt to define where he thought he was in terms of the priority of patients in Emergency.

Where patients were requested to wait within the Emergency Department affected patients differently. Generally, it seemed that if patients had to wait, they preferred to do so in the waiting room. "Oh, I think probably waiting out there (Emergency waiting room) (is better) because there's so much going on you know. At least when you're here (in the exam rooms) you're just looking at all these things on the wall". The placement of a television in the waiting room was also discussed as being beneficial for some of the patients while they were waiting to be seen. Another patient felt that while she was waiting in the examination room, she would see and talk briefly with the nurses. This contact with the staff made the waiting much easier for the patient. "No, the waiting room is not that bad, but once they (Emergency staff) take you in there (examination room),...especially if you gotta get x-rays and all that done. Sometimes you think they forgot about you". It was apparent from this patient's comment that once she was placed near x-ray, less contact with the nurses not only left the patient with the impression that she had been forgotten, but also made it more difficult to wait.

Nonurgent patients expressed their expectations of "how" the care was to be provided to them in the Emergency Department. An issue which arose consistently was the question of legitimacy. Legitimacy referred to being doubted as to whether a patient was "ill enough" to be in Emergency. Patients often felt as though they were victimized by a health care system which, on the one hand, established the Emergency Department as the only alternative for medical care and, on the other, chastised patients for using this alternative. This doubting by the staff of patients' assessments not only upset and insulted the patients, but made them feel ridiculed. "I think the person in Emergency (staff) treats

every situation differently. But if he (the patient) perceives the situation as being important and people (Emergency staff) do not, he finds it very frustrating". "What the person says is valid, it's worthwhile to listen to because it's important enough rather than to just make a decision (as to the severity of the illness)". From past experience, patients had the expectation that the severity of their illness would often be doubted by the Emergency staff. As a result patients often believed they had to be sure to "act" and "look" ill enough if they were going to be believed once they were in Emergency. "I think the only way to convince them (the Emergency Staff) is to let them know how you feel, to show them what kind of priority this is to you, and to hope there's not a large amount of people that need help. If there is, it doesn't matter what your problem is... you lose".

It was very clear to patients that nursing staff controlled how and when they would be seen by the physicians. Therefore, it was important to patients to not only influence and convince the Emergency nursing staff that they were ill but that they were ill enough to be seen before other patients. "They're (Emergency staff) making decisions and they have the upper hand. They have the resources and they have the manpower and the expertise to do it. Therefore...all I can do is try to convince them or persuade them, but basically it's (when the patient is seen) out of my control...from then on". One patient also believed that not only was it how he acted that influenced the Emergency staff's perception of him but, also, how he was dressed. He felt that the Emergency staff's behavior and decisions were influenced by a patient's appearance. "You've (staff) got to treat everybody as an individual and (remove) those preconceived notions whether I come in dressed as a marine or I come in with hair down to my back and torn jeans". This patient, in particular, felt such labelling may be more prevalent due to the location of the hospital and its proximity to the inner city.

Patients therefore expected to be treated with respect and understanding and not be judged or labelled as abusing the health care system. Respect was defined broadly to

include respect for a patient's assessment of his/her illness, appreciation of their concern, and of their decision to come to Emergency; respect for a person's culture; and respect for the patients' privacy. One of the most predominant expectations was the need for nonurgent patients to feel valued and comfortable with their decision to come to Emergency. "I expect to be treated in a common manner (just like everyone else). I expect to be treated as a person. I expect good medical help. I expect people to be responsive to my needs. I have a problem and want someone to help me". Respect was particularly important to an older female patient who remembered how she felt as an inpatient when she thought she was not treated appropriately for a woman her age. "If I were a child it would be different but, ...I'm an older lady and ...I don't like being pinched on the bum...I'm an elderly person, don't treat me as one (a child) but just respect, respect". One individual, though appreciative of the busyness of Emergency and the apparent difficulties for staff in the area, maintained that regardless, respect was a very important expectation he had for his care in Emergency. "Respect, I think that's the thing. All of us can be smart enough to realize the situation is stressful, you're (the Emergency staff) overworked you know. But I think ... respect... anybody has time to give them (the patient) their respect". One patient summarized this view, "Understand my situation for what it is and I'll try and understand yours".

Although one patient identified his expectation as "dignity", it was similar to respect in that he expected the Emergency staff to treat him as an individual and to acknowledge his decision concerning his illness to be valid. "Dignity is being treated how you would like to be treated". This patient believed that people within the health care profession enter it because they respect people. It was clear to him that this was an expectation, therefore, of any individual working in health care. The patient felt that through experience, something within the professional person may change, regarding their ability to respect patients. "I know every individual in (each) profession... choose it

because they love it and after awhile, they succumb to the realities of the situation and then maybe they don't treat people like they would have thought they would have treated people from day one".

An element of respect was demonstrated by the Emergency staff by keeping patients informed about their care, that is, when they were to be seen, why they were waiting so long, and any test results or information regarding their care. Patients noted that keeping them informed was also important to their feeling valued, that is, they were important to the staff. "That's the big thing. You know if nobody comes by in an hour, an hour and a half, well you think maybe they just really forgot about you. For those patients who had, at one time, to wait several hours in Emergency for an inpatient bed, it was apparent that being informed was very significant to them. "You felt informed, you knew what was going on and that's important"; "I think if I knew why my goals were not being accomplished then I wouldn't be that hostile".

Respect for one's culture was an extremely important expectation for a Spanish speaking patient. She felt strongly that attempting to communicate when a language barrier was present demonstrated respect for individuals from different cultures. Through the assistance of the patient's husband and/or her daughter, during the interviews, her concerns were identified, "Actually you know, in a city like where we live now, some people they don't speak fluent English and they need help right away. We expect somebody to try to understand the people who come. When you come ... (you) don't know what papers (you) need, (you) don't know where to go, and ... that's where the ...guage comes in".

Maintaining patients' modesty was an important expectation identified by one of the male nonurgent patients. This was of particular significance in Emergency because patients were, he believed, most vulnerable. The expectation was that Emergency staff would protect a patient's modesty and dignity if the patients were in no condition to care

for themselves. This patient also discussed how uncomfortable and awkward it was also for the passerby. "It's okay for a girlfriend, it's okay for a sister, but you can see her half-naked. It doesn't matter. But to see somebody you don't know, I mean it's sort of embarrassing to think everybody's seen (you)".

Caring from Emergency nurses was an important expectation identified by patients. Caring was described as communicating empathically and appreciating the patient's concern. Caring was communicated when the staff stopped to smile at the patient; it was reassurance that they will be looked after and they will be alright. Caring was "taking the time" actively to listen to patients. The importance of caring was so valued that it was seen as an essential quality in any health team member. "Well, it's (working in Emergency) got to be a tough job. I'm sure it's a labour of love, and very caring people get into it, but I think when they don't care anymore, it's time to get out". It was clear that caring was a critical component of the quality of nursing care provided to the patient. For one elderly patient, the positive experiences she related regarding her previous inpatient admissions were very closely associated with the "caring" that was demonstrated by the nurses. To her, caring meant valuing patients as individuals to want to get to know them a bit more, spending a few extra moments with them, and doing the "extras".

An aspect of caring which was identified by the patients, was empathy. Since patients described themselves as anxious about pain relief, they needed to be made to feel they had come to the right place because of their concern about their illness. Consequently, empathy was important. "That support...I call it empathy. I think it makes the person, the injured party more relaxed and comfortable". "They can show it (caring) with their smiles, with a realization that you don't know what they're (the patient) going through, but at least you're empathic enough that you probably feel that way". Associated with empathy, was reassurance,

> I don't mind them (the staff) talking about the injury and maybe comforting me, 'Oh, it's not so bad', and 'We see this kind of thing all the time and you're going to live'. That's empathy, and that's a nice consolation because it avoids me asking shifty questions about nothing. You know, you go in (to Emergency), you're high on adrenalin, you're maybe a little bit emotional because you're injured, and if they talk and chum it up a little bit and just say, 'You know, we see this all the time, there's no problem, you're not going to lose your toe, or your not going to lose you arm'.

The need to fulfill this expectation effectively was addressed very succinctly by one patient, "In my mind, the only way a patient's care could be improved is not so much by the quality of the medication, but by the understanding of the nurse or the doctor. That improves the patient's situation".

"Caring" was also defined as the technical/professional competence of assisting patients. This kind of competence was very much an unspoken expectation. What was valued and discussed to a greater extent was the emotional, human element in caring.

> They (the nurses), were always fluttering about me. It was their job, I suppose, they had to watch the monitor to make sure that my heart was beating normally and functioning normally. ... That's why they're nurses. I mean, they are there to care for patients, ...and the care they gave me was super; little extras. Now this is something she (the nurse) didn't have to do, but she did it and she spent about fifteen minutes with me. That's a long time to spend with one patient". "I can't have enough praise for those nurses, with the care they gave me. They were super cause...they gave you their best.

Active listening demonstrated caring and also reflected concern and value for the individual. "I expect you as a nurse to be a good listener". How well Emergency staff listened to patients was significant, for example, to a patient's boyfriend who watched an

interaction between a physician and his ill girlfriend, and felt that effective listening skills on the part of the doctor could affect obtaining an appropriate history and ultimately in the effectiveness of the care of the patient. The boyfriend appeared frustrated and interpreted the apparent "poor listening" to belittling the patient's illness. "Working in Emergency, you're under a certain degree of pressure. Everybody needs help but to what degree that help has to be rendered is really a priority with the doctor. In this case there are degrees of how you approach people and how you respond to them. If you keep cutting them (patients) off, they may feel that they don't want to impart information to you".

Seven of the nine nonurgent patients believed caring to be a critical component of the professional nurses' role (not necessarily the physicians') and influential in how a patient perceived their experience in Emergency. It was interesting during discussions to understand how two of the patients rationalized an "uncaring" attitude of the nurse and/or physician. "Nurses do try to be remote from the person (patient),...from a personal point of view and try to be professional and treat everybody professionally, but more or less like a number". A male patient appeared to attempt to dismiss the need for "caring" from the nurse, however, later he went on to discuss how important it was to listen and appreciate patients' concerns regarding their perceived illness. "It's a lot of people to turn over (to see in Emergency), and have them all feel like they've been treated with tender loving care as they leave. I don't expect tender loving care". For this patient, his definition of caring obviously focused on listening and empathy.

In discussing expectations of Emergency nurses with the patients, there seemed to be a relationship between how positive the experience in Emergency was, and how much the nurses demonstrated the various aspects of caring (technical and emotional), and how significantly the patients viewed the role of the Emergency nurse in the patients' care. When one patient was asked if the nurses in Emergency had any particular impact on their care, the patient commented "none whatsoever". Another patient had similar feelings.

She regarded the role of the Emergency nurse as very insignificant, with only one purpose. "All I expect of them (the nurses) is to take me into a room and get me ready to see the doctor, that's all I expect from the nurse".

Clearly, the nonurgent patients interviewed had similar expectations of the "type" of care they needed, and "how" the care should be provided. Both of these factors influenced how patients perceived not only the effectiveness of their care, but also the level of satisfaction attached to the experience.

The Visit Of The Nonurgent Patient

Nonurgent patients discussed several issues when asked what their experience of coming to Emergency was like. How long and where they waited strongly influenced how patients perceived the quality of "care" they received in the Emergency Department. If the patients were seen expediently, their perceptions of the role of an Emergency as quick, fast service, were reinforced. "They're (the Emergency staff) good, they're good, I didn't have to wait long. First time I waited a little bit longer, not a heck of a lot". "Well, they're (the Emergency staff) okay ... I have no patience waiting anyway..never have". Any amount of waiting was difficult for some patients. "Well, the care's okay. Just that maybe ...I didn't have to wait so long once they get (into Emergency), just the waiting". One of the nonurgent patients who waited more than two hours to be seen by an Emergency physician found it quite frustrating. "I sat there (in Emergency) so damn long, I was ready to go to sleep when they (the Emergency staff) finally came".

The length of time that a patient considered to be acceptable and not reflect inefficient care was an individual matter. "Aside from faster service, I don't know. That's all I want. Faster service and ... just a little bit of treatment...I'm on my way back home".

Two of the patients were very pleased with not having to wait at all. One patient only had to wait "ten minutes". Such short time frames left patients very satisfied with their care.

Patients' concern regarding the waiting in Emergency included the time it took to go through the admitting process. One of the patients seemed to feel that since he had his "patient identification card", the process should be much more expedient. This influenced his perception of the efficiency of his visit, the quality of the care and ultimately his satisfaction. "I thought that card (Patient Identification Card), would be sufficient again for this particular occasion and it wasn't and I thought the initial reception was a little bit long and lengthy. I mean I had my ID number. I just wanted to get in and out as fast as possible". Initiating the admitting process also seemed a bit confusing to another patient who had not been to Emergency frequently and felt a bit overwhelmed. "Coming in, ... it's a little confusing. ... Today (there) seems to be a lot of people".

There was a sense of concern expressed by four of the nine nonurgent patients who felt the legitimacy of their visit to the Emergency Department was in question by the Emergency staff. "Well, like with this arthritis, I've had to make more Emergency visits than I care to. I have to say, other than the odd doctor who will say, 'Look, this isn't a cut or something I can see or a (broken) bone that I can x-ray, so go away'. That has happened, when I have been in severe pain and driven a hundred miles to get medical service". This patient went on to express a feeling of being labelled as an abuser of the health care system. "I understand you get inner city hospitals, you have junkies, you have all the problems coming in here, but I don't have a little sign on my forehead that says I'm not one of these people. I don't try to abuse this situation. As a matter of fact, I feel I deal with a lot of pain a lot of people wouldn't and it urks me when I get treated that way".

The need to legitimize the severity of the illness was discussed by another patient who related a feeling of not being "believed" (by the Emergency staff) that he was as ill as

he said he was. "There is a sense when your doctor (in the Emergency Department) doesn't think it's important and you think it's very important". This feeling was also expressed by another nonurgent patient. He felt however, this was best handled by behaving very well in Emergency which ultimately gave the impression that the behavior of the patient in the Emergency Department influenced how well one would be treated by the staff. "I find that as long as you're courteous, (you) don't have any problem. It's when you're not courteous, then you have a problem". The influence of patients' behavior upon their care in Emergency was validated by another patient who also felt that, "If you give him (Doctor) a bad time or you give the nurse a bad time, I would think that you would be set back a bit, so it's in your best interest ...not to give them a bad time". In direct contrast to these feelings expressed by several patients, one young man who utilized the Emergency Department as his main source of health care was quick to point out how comfortable he was in seeking assistance through this source. He commented, "If I have something to deal with that needs attention right away, I just come to the Emergency because I don't feel any negative impact coming here".

A concern expressed by an older female nonurgent patient, was the need to be "ill enough" to come to an Emergency Department. Even though she ultimately decided to come in for vague chest pains, it was evident that she felt very uncomfortable in making that decision. "I'll probably be blushing when I get there (Emergency Department) and realize that it was nothing at all".

The need to legitimize a visit to an Emergency Department when the patient was directed to do so by a family physician was criticized by one individual. Although the doctor had directed the patient to meet him in Emergency, the patient was made to feel very uncomfortable by the staff for utilizing the Emergency Department and subsequently felt unfairly treated by the staff. "What urks me is that if I want to go see my Doctor and he'll send me over to Emerg. for treatment because they often can't treat me at a clinic.

Then you get the rolling eyes and ... you know, it's like, 'Hey lady (to the Emergency nurse), I just have been to a Doctor, we have been through all this'." Another patient also believed that if the Doctor didn't feel you were sick enough to be in Emergency, you would almost be punished by making the patient wait a long time for treatment.

In discussing "waiting" in Emergency with the nonurgent patients, feeling informed regarding the wait seemed to decrease the patients' anxieties. "Well, they (Emergency staff) came and they've already told me that they're backed up, so, I'm not expecting him (the Physician) to walk through the door any second and I think that's nice that they (Emergency staff) let you know that it's going to be a little bit longer wait". As it was important to inform patients of their anticipated wait in Emergency, so was maintaining contact with patients, while they were waiting. This reinforced that they were still being cared for.

Two of the nonurgent patients had very clear expectations of their visit. These patients' satisfaction was very dependent on whether the visit resulted in meeting their needs, for example, "Oh,...(you) just spend most of the time just waiting there, that's about it. It takes too long in there (Emergency) and then (you) end up with nothing, like, they (Emergency staff) don't even give you (anything) for pain". It is evident that this patient, whose purpose for coming to Emergency was to obtain analgesics, was dissatisfied when her cast was removed and no analgesics were provided. The patient who required a refill for his prescription was very pleased with his care. Not only was he seen by a physician immediately, but he also obtained his prescription without any difficulties. "I feel really good. I accomplished what I wanted accomplished. Actually, I didn't expect this (type of treatment) at all".

Aside from the individual effects of the wait prior to being seen, patients in general, felt they had received "wonderful service". An elderly lady was very pleased that when she was coming into Emergency, the security officer offered his assistance as she

was getting out of the car. "He (Security guard) came...I came out of the car and he made sure I (didn't fall). He thought, 'Well, she's an older lady and she might stumble and fall'." Such attentiveness was identified as good quality care by another patient as well. It was also apparent that her evaluation of her visit was based on comparing it with either previous visits, or with visits of individuals she knew. "Everyone's usually very nice. I've never had a problem (in) any area of this hospital. Everyone's always been very nice".

Consideration of one patient's inability to speak English was influential in how she and her family perceived the quality of care provided in Emergency. The effort to communicate effectively, in a more comfortable manner for this patient, was very much appreciated, resulting in the patient feeling very satisfied with the care she received. "When she (the patient) was there (in Emergency), she saw two employees that were Spanish. They just seemed to know that my parents were Spanish and they came up and asked them if they needed any help".

One of the nonurgent patients discussed safety precautions and AIDS. The patient, prior to being examined was very concerned about AIDS and had asked the nurse if the doctor who would be seeing him was wearing a wedding ring. His concern regarding homosexuality and the transmission of AIDS was very important to him. A part of this concern seemed to be the lack of knowledge and misinformation.

> I think, I'm comforted sometimes more when I do see doctors wearing gloves or anything like that. Nobody really knows how it (AIDS) can really be spread or how simply it can be spread and you know, who wants it? I mean somebody told me once if you spit on your desk and it's on the desk for a week and somebody comes back and they cut their hand and the blood falls on the desk from the cut or whatever, you can still catch it (AIDS)...I would just prefer to be cautious rather than sorry.

Nonurgent patients discussed their visit to Emergency in relation to legitimacy, waiting, fulfillment of expectations, satisfaction with courteous and considerate "service", as well as safety issues. Frequently patients felt the legitimacy of the seriousness of their illness and their decision to visit Emergency seemed to be in question by the Emergency staff. This not only insulted the patients, but resulted in patients feeling it was necessary to modify their behavior to what was expected by the Emergency staff of an ill person. Patients' reaction to "waiting" in Emergency was very individualized. The length of time patients had to wait to be seen by a physician, as well as where they were required to wait, had implications on how patients perceived the quality and effectiveness of their care. Patient satisfaction was largely dependent on whether the visit to Emergency resulted in meeting the patients' perceived needs.

The Urgent Patient's Experience In The Emergency Department

Urgent patients were defined as patients presenting to the Emergency Department with a condition which must be treated within a period of a few hours to decrease the possible risk of further injury or increased severity of illness; disorder is acute but not life-threatening (Lavenhar, Ratner, & Weinerman, 1968). Four urgent patients were interviewed in order to differentiate between the experience of the nonurgent patient and that of the urgent.

Reasons for Coming and the Decision-Making Process

Three of the urgent patients decided to seek medical assistance for known pre-existing conditions or illness which became more acute, such as Crohn's disease, a

postoperative patient with complications, and an elderly gentleman with weakness and Congestive Heart Failure. The fourth patient came into Emergency as the result of injuries sustained in an assault within the inner city.

Mr. W. came into Emergency from a rural town, due to an increase in weakness resulting in difficulty walking. Mr. W. had driven into the city earlier for an appointment with an optometrist the next day, however he became progressively weaker the day before his appointment and decided he had to go into the hospital to get medical attention. "Oh, I was sick, like I couldn't stand on my feet".

Ms. X came to Emergency seeking pain relief from Crohn's disease which she had had diagnosed six years earlier. "The pain felt like it was going to put me through the wall, it was that bad". Her symptoms began three days prior to her admission. Following a thorough self assessment, a variety of self-care methods were attempted at home. "I came home from work yesterday feeling very nauseated and in a great deal of pain so I took Gravol and one of my pain killers...but it wasn't a restful sleep". Ms. X recognized that it "was time" to go to Emergency when her usual efforts to control her pain proved to be ineffective. "The nausea started about maybe yesterday. It was the eyes first, and then I get a little sore inside my mouth. I get all these clues, I just don't always clue into the fact that they're trying to tell me something until like yesterday, the pain hit and then the nausea. Following the use of Flagyl, which normally was effective in reducing her symptoms, she recognized that since it was not working, "...something weird's going on here, this could be bigger than you can handle so go get help". Based on her previous experiences with her chronic illness, Ms. X. had learned to identify warning signals which meant she needed to seek additional medical assistance. "Once you get the pain, and the pain and the diarrhea usually go together, so once that hits we know what's going on ...let's get in (to the hospital)". Whenever possible, Ms. X. contacts her family physician,

however since it was early in the morning (0530 hours), she decided her only recourse was the Emergency Department.

Mr. Y. came into Emergency at 0045 hours after being assaulted in the inner city. He had been beaten quite severely and was experiencing pain in his right arm, which was later diagnosed as a fracture. Following the assault, Mr. Y. had sought refuge for the night at a nearby hostel. Mr. Y.'s initial decision was to wait and see if his arm would stop hurting, however this was not to be the case. "I don't know, my wrist was kinda hurtin', but I didn't think it was that bad". He then requested the staff to drive him to the hospital since he had no means of transportation.

Mrs. Z. came to the Emergency Department as the result of difficulty eating, weight loss, and dehydration. She had had two back surgeries, the most recent being approximately one month prior to her admission to Emergency. Mrs. Z had been ill for two to three weeks with flu-like symptoms and waited to see if they would subside. She saw her physician after one week, to obtain some medication which would relieve her symptoms. After being on the medication for a short period of time, she reacted to the medication and discontinued its use. Throughout this time, Mrs. Z was also guided by suggestions from her husband, who is a physician. When it appeared she was not improving as she and her husband thought she should, Mrs. Z. decided she needed to check back with her physician when her condition deteriorated during the night. Since it was early in the morning, Mrs. Z. decided to come to Emergency.

Three of the four urgent patients interviewed, came into Emergency because of a known or existing illness. The nonurgent patients may have had a previous health problem, however, they came into the Emergency Department because they either required additional treatment or pain relief, or "wanted to find out what was wrong" with them. When the nonurgent patients were questioned about the signs and symptoms they identified, which had influenced their decision to seek medical attention, they expressed a

need to "find out" quickly what was wrong with them or to obtain some form or quick treatment and go home. The urgent patients initiated a more detailed, thorough assessment of their condition, initiating various self-care methods before deciding to go to Emergency. The three patients with a history of chronic disease also seemed to acknowledge the fact that they would most likely have to come in as an inpatient. There was no "quick fix" that could be found in the Emergency Department that could relieve them of their problems, but rather, it would take a few days to alleviate the severity of their illness. The ramifications or outcomes of the Emergency visit, therefore, differed in the majority of urgent patients interviewed. For the nonurgent patients, a quick trip to the hospital and returning home "within the hour", was very different from the urgent patients who seemed to try to do everything possible to improve their condition before having to accept that they had no alternative but to come into Emergency. For some urgent patients, going to the Emergency Department meant the first step in the admission process. "Yeah, when you're already scared to stay at home, you rush in". For others, the sense of urgency regarding their illness, and the need to be seen within an Emergency Department to access necessary resources which were only available within a hospital setting, was more pressing.

Knowledge of Resources

Selection of Health Care Service

Urgent patients' knowledge of resources for medical care seemed to be largely influenced by the presence of a chronic or prolonged illness. Through the course of their illnesses these patients had become much more knowledgeable as to the availability of resources and access into the health care system. For other urgent patients who did not

have a chronic illness, but rather, an injury or health concern that required treatment within a period of a few hours, the knowledge of health care resources was limited, similar to a number of nonurgent patients.

Family Physician

Unlike the nonurgent patients who seldom or never saw a family physician, the urgent patients generally had very regular contact with either their family physician or specialist because of more prolonged or chronic illnesses. It seemed that the urgent patients had utilized various health care resources in the past which had resulted in an established pattern of seeking medical assistance. The nonurgent patients often just simply wanted to see a physician, "any physician", while the urgent patients were much more planned in terms of their help seeking behaviors, particularly if they had a chronic illness. "Yes, if at all possible, I go in to see my own physician first, and usually all I have to do is call up and say, 'I'm in trouble', and they (the office staff) will tell me, 'Okay, (or), he's busy'. Quite often lately it's been, 'He's busy today, go over to Emerg., they'll call him'. That's my first line rather than come in here (Emergency)". As is the case for many urgent patients in Emergency, Mr. Y. did not have a chronic illness. In his case, based on an assessment of his injury, he did not perceive that there was any alternative but to seek medical attention from an Emergency Department due to the need for resources which were only available in a hospital setting.

Within the group of urgent patients interviewed, there was a noticeable difference in access to health care services. The wife of the physician most often would see "specialists" for health concerns and did not see her family physician as often. When the need arose, her husband would contact the appropriate specialist, one of his friends and/or colleagues, and arrangements would quickly be made for her to be seen. This patient

recognized that she and her family were fortunate to have greater ease of access to the medical/health care system because of her husband's occupation. The other urgent patients depended solely on their family physicians, or the Emergency Department, for the treatment of their health concerns. It was noted that the urgent patients with chronic or prolonged illnesses were definitely much more knowledgeable regarding the "system" than the group of nonurgent patients.

The Native urgent patient also discussed another resource in terms of seeking health care, the Indian doctor, or Medicine Man. His strong belief in the capabilities of Native medicine was apparent. The experiences of significant others who had been treated by a Medicine Man also influenced Mr. Y.'s decision of sources of health care. "I know this guy in North Dakota, an Indian, a Medicine Man. He cured a few people of cancer. Doctors said they had no hope, so they went (the patient) to see this old man. Six months later (the cancer patient) came back to the hospital and he was all cured. Indians, we all have our medicine".

Since Mr. Y. lived a more transient lifestyle, his knowledge of the location of other resources such as Medi-Centres was more limited. He was familiar, however, with the location of the hospital and the role of the Emergency Department as a source of medical assistance. Otherwise, it seemed his main recourse when he was ill or injured was to treat himself, or "wait it out", which was similar to the initial "self-care" process the nonurgent patients had identified. "I don't know, I never go see the doctor for most illnesses". His only contact with his family physician, was to renew his prescription for analgesics on almost a monthly basis. "I see him about every month, or whenever my pills run out".

All four urgent patients had an established family physician for a number of years. The Native patient stated that he had had a family physician for several years, other than when he was living in places for only short periods of time. Since a hunting accident at the age of fifteen, when a bullet became permanently lodged in his head, he had

experienced migraine headaches for which he required medication. Renewing his prescription seemed to be the only reason he seemed to utilize his family physician. The patient appeared very sincere about liking his family physician and referred to him as a "nice old man".

The remaining three urgent patients maintained regular contact with their family physicians and sought assistance through them first when faced with health concerns. There was a sense that a more thorough selection process had been undertaken to seek a physician who would appropriately meet their needs. The patient with Crohn's discussed a lengthy process of trying to find a physician who would work with her as a partner in her care, as opposed to autocratically dictating his plan of treatment to her. "I'm honest. I'll say look, you may not want me for a patient. If you do, great, let's work together. If you don't, I'm not going to fight with you. I'm just going to leave". Ultimately the physician who was found to be most effective for her was referred by her sister. "My sister was seeing the doctor that I have now and raved about him, so I went to see (the physician) and we got along".

It was very important for these urgent patients to maintain continuity in medical care. "I feel better about people (who) have regular doctors,...make appointments, and get to know their patients". For urgent patients with chronic illnesses, it was not feasible for them to feel they could "just fix" the health problem. Their conditions required greater continuity of care over longer periods of time.

The selection of a family physician was much more limited for the elderly gentleman from a rural town. There were two physicians in neighboring towns. He did appear confident in the capabilities of his physician and the knowledge that his physician would refer him to someone in the city, should he require a specialist or different expertise. "He sends me to ... (for a) referral". The influence of this patient's family physician in the decision-making process was evident. It seemed that if there was any

doubt by the patients as to the source of health care, family physicians would play an important role in the decision and recommend what they felt was the most appropriate referral.

For the urgent patients, an important factor in their selection of a family physician was that he would see them quickly when the patients contacted him/her with a concern. "I've never ever called him (family physician) for myself or the kids when he couldn't see us within a day". Ensuring that their family physician had admitting privileges was another important criterion. One patient decided against a certain family physician because she became aware that the physician did not have admitting privileges at the hospital she utilized. "I didn't go to him then because he doesn't (did not have) admitting privileges". When the need arose that she had to be admitted, it was important to the patient that her family physician continue treating her while she was in hospital, rather than admit her under a different physician with whom she was not familiar.

The urgent patient whose husband was a physician advocated the need to utilize a family physician, however she often by-passed her physician when she and her husband identified that a specialist would be required. "When you're just not feeling well and you have ear aches, ... you think you have a flu, or a pain somewhere, I think you go to a family doctor and hope ...he refers when it's out of his area of expertise". "I've usually gone to specialists for anything. I've occasionally gone to a G.P.". She also acknowledged how difficult it was to arrange to see a specialist and therefore, advocated the importance of a "good" family physician, in which case it may not always be necessary to see a specialist. "Some of the specialists are so darn busy that it's hard to see them, it's hard to talk to them. You know I still think a good family doctor can pull things together".

The difficulty over limited physician's hours was a concern for urgent patients, as it was for the nonurgent. "It was too late by the time I got a hold of him (the family

physician) on the phone (to see if he was in his office)". Since it seemed the urgent patients in general had greater experience in trying to access their physician, they also had an established plan of action. If the family physician was unavailable, they would go to the hospital where he or she had admitting privileges, or normally referred them to, knowing that this was what had been arranged in the past, and had worked well.

The decision to utilize a family physician was an alternative for three out of the four urgent patients interviewed. Both nonurgent patients and urgent patients expressed a concern regarding limited accessibility to their family physician due to office hours and vacation. However, the urgent patients with chronic illnesses felt comfortable that they could contact their family physician and arrange to be seen quickly due to the frequency with which they saw their physician, and because they had established such a relationship with them. Proximity and convenience were not important factors in choosing a family physician. Urgent patients seemed more selective in the process of choosing a family physician who would most appropriately be capable of caring for them in a manner which was most comfortable and suitable for them.

The need to maintain continuity of care through a family physician was critical for three of the urgent patients, as was the hospital where the physician had admitting privileges. The influence of the family physician in the decision of appropriate health care services was more pronounced in the urgent patients. Either a process had been established between the physician and the patient in advance, or from previous experience, or the patient would seek assistance in making the decision by contacting their physician. For the urgent patient without an existing chronic illness, the utilization of his family physician was similar to other nonurgent patients. He only utilized his family physician when he had a specific problem or need, such as a repeat on a prescription.

Medi-Centres

Although all four urgent patients were familiar with what Medi-Centres were, none of them saw them as a viable option. The Native patient had never considered Medi-Centres as a source of medical assistance. His sources of health care were primarily self care, his family physician when he needed a prescription refilled, or the Emergency Department as a last resort.

Mr. W. who was experiencing weakness and difficulty walking upon admission to Emergency, lived in a rural area and did not have access to a Medi-Centre. His options to consider in accessing medical care consisted of either his family physician who lived nine miles away, or referral to a physician in the City which generally meant the Emergency Department.

Ms. Y., a patient with Crohn's had utilized a Medi-Centre in the past prior to the progression of her illness. Although she had a family physician at that time, her main rationale for going to a Medi-Centre was the unavailability of her own physician. "I haven't, for the last two or three years (utilized a Medi-Centre). I used to before that when I couldn't get into my own doctor, but as the problem got bigger...less and less doctors understand what I'm going through and finding somebody I can deal with on a one-to-one basis where he's not trying to put me down or tell me, "No, you don't know what you're talking about". As Ms. Y.'s condition advanced, she identified a need to not only maintain consistent care, but also ensure that the physician she was seeing valued her opinion and input into decisions involving her care.

One of the urgent patients recognized the advantage of Medi-Centres when it came to discussing hours of operation and flexibility, however, she was quick to point out that she would never utilize that source of medical assistance. "See, the thing about Medi-Centres, I would say in their favor, I don't know what their hours are, but they are

certainly longer than most doctor's offices". Her concern related to increased costs of health care as a result of such "abuse" or "overuse". "I think that maybe they (Medi-Centres), save Emergency... from seeing things that really don't belong in (there) because they're pretty minor, but I think they're costing our Provincial Health Care System a fortune. People are going to them because they're afraid in many cases with things that would go away by the next day if they waited".

Frequently patients who have been treated in a Medi-Centre, follow up with their own family physician the next day to validate the diagnosis and treatment prescribed by the physician at the Medi-Centre. Since the patients are following up on the same illness which was billed once already to Provincial Health Care the day before, the family physician can not bill a second time. "They're calling their doctors the next day to check if the diagnosis was fine and the doctor's don't get paid for it". Therefore, there is substantial impact on the health care system as a result.

All urgent patients were knowledgeable regarding Medi-Centres as a source of medical assistance. Although one urgent patient had utilized a Medi-Centre in the past when her family physician was unavailable, she no longer did so since she was diagnosed with a chronic illness. Unlike some of the nonurgent patients, Medi-Centres were not viewed as a viable alternative by urgent patients due to either a perceived lack of continuity of care, or the inability to access a Medi-Centre in the rural area. When the urgent patients were unable to contact their family physician, or had an illness or injury which they felt required resources only available through an Emergency Department, the Medi-Centres were not a viable alternative.

The Emergency Department

The role of the Emergency Department as a source of health care was in some ways, perceived very differently by the urgent patients. Similar to nonurgent patients, the Emergency Department was seen by urgent patients as an area comprised of highly-skilled professionals who deliver a high standard of care, with ready access to diagnostic tests and procedures. "I guess I was worried too because so much was going wrong. It was ... a relief to know that the blood tests, when they came back, they (Emergency staff) let me know what the results were". The perception that the opportunity to see a specialist much more quickly was also prevalent among three of the urgent patients. In addition, the convenience of 24 hour operation was a great benefit to the patients, when they had exhausted their other alternatives in seeking medical assistance.

Unlike the nonurgent patients, the Emergency Department did not represent a "quick-fix" alternative, with the exception of the Native urgent patient. Following an individual assessment of the severity of the illness, each patient attempted numerous methods of self-care. The first source of medical assistance that was sought out by the remaining patients was to see their family physician, in whom they had a great sense of trust and confidence. If they were unable to contact their physician, the patients generally tried to delay admission to Emergency as long as possible. One such patient commented, "I want to be sure that I need to be here (Emergency)...I don't like my life disrupted this way either". The elderly gentleman from out of town also expressed a need to do all he could to prevent having to come into the hospital, "I come as the last straw...when you're just about on the floor". To this group of patients, the Emergency Department represented an entry point to the hospital as an inpatient. Since they had been through this process several times before, it was one they tried hard to avoid. Only when all attempts to improve their condition were ineffective was the inevitable accepted. "I have to be

convinced myself that , yes, you need to go to the hospital. You don't want to go do this, but this is a reality of life. I have to do that even when I'm sitting down here (in Emergency) and I know that I'm going to be admitted. I ... revert to being a little kid and I won't come in here (Emergency). I do not, under any circumstances want to come in here. Now it's an internal fight".

Urgent patients also had a very different perception of "waiting" in Emergency. Contrary to nonurgent patients who accepted a "reasonable" period of waiting, but whose goal was to get home as soon as possible, the urgent patients appeared to have the most difficulty "waiting" before they came into Emergency. This waiting at home consisted of desperately trying to do everything to prevent it from being necessary to access medical attention via the Emergency. Urgent patients did view the Emergency Department as an area where care was given efficiently. This was important once patients decided to come in since they had generally delayed admission to Emergency, and therefore sought relief, when they did arrive. Waiting for periods of time in Emergency for an inpatient bed resulted in different experiences. One patient discussed waiting overnight in Emergency for a hospital bed, "When you're sick you don't care (where or how long you had to wait for a bed". For two of the urgent patients, waiting was not so much the issue, as where they waited. They felt "on display", lacking any privacy, and felt that the nursing staff tended to ignore the patients in the hallway. One of the patients said that it almost felt as though her care in Emergency was over once she was placed in the hallway. She was almost in limbo, waiting for a bed.

Urgent patients were similar in their perceptions of the capabilities and advantages of the Emergency Department as a health care alternative: highly skilled professionals

who offer a high standard of care; and quick access to diagnostic tests, procedures, and specialists. Since the urgent patients' illnesses are more serious and require medical intervention within a few hours, the speed with which urgent patients can be seen in

Emergency and treated, as well as the convenience of 24 hour operation, was essential. For those urgent patients with chronic or prolonged illnesses the Emergency Department was a second alternative when the patient was unable to contact his/her family physician, or, as the first source of health care when the patient's condition required more immediate intervention. As with the nonurgent, some urgent patients may view Emergency as a "quick-fix" approach to health care, seeking only to obtain quick, convenient treatment of a problem.

Past Experiences

Urgent patients' past experiences, especially those with chronic illnesses, were very significant in guiding their decisions as to when and where to seek medical attention. Their past experiences with their illness were used as a guide or assessment tool in evaluating their status. The patients would base their decisions to seek medical assistance on what signs and symptoms they experienced in the past, what self care methods had previously been effective, and how ill they had been before they resorted to going to the hospital. Through the urgent patients' past experiences with their illness, three of the patients stated their first source of medical assistance would be to contact their family physician. Even though the nonurgent patients expressed a level of trust and loyalty in their own physician, there was a much stronger bond identified between the urgent patient who had a chronic condition and her family physician.

Urgent patients' recall of past experiences focused more on how they "lost control" as a patient and how their behavior had changed as a result of increased hospitalization and contact with the health care system. Nonurgent patients really did not seem to internalize what it was like to be in the patient role. Their perspective was more as individuals who just wanted treatment. In contrast, urgent patients' past experiences of

what it was like to be a patient, centered around a sense of helplessness and powerlessness. One urgent patient used the analogy of being a baby to describe what it was like being a patient. "Imagine you're a baby but have the mind of an adult and people are doing things to you. You can't talk, you can't scream, you can't do anything to help them understand that they're treating you badly, so you cry and then you get sedated so that they can control you". The feeling of powerlessness and lack of control was also experienced by an elderly gentleman who came into Emergency as an urgent patient. He related some of his past experiences, and how he felt he needed to struggle to maintain some control. "He (physician) told me, `If you're not going to listen to what I tell you, don't come here any more'." This patient believed that as a patient you are expected by members of the health care team to "sit there and listen".

Urgent patients perceived a greater loss of control in the hospital. These patients required treatment and did not feel they had the option to leave and/or go to another facility. Since admission was required, these patients felt less able to reject a prescribed treatment. Failure to do so was not without repercussions from the physicians or nursing staff. Patients felt that when they spoke up for themselves or refused treatment, they would be "labelled" as difficult patients. "You feel absolutely helpless, but your mind keeps telling you to do something. I've screamed at more than one doctor down there (in Emergency), telling them, 'Look, you've got to keep me informed.' Which is where I got the "impossible" patient, the "bad" patient, the "rotten" patient labels. And once you've got that label you can't deal with that person. It's impossible because they will sedate you rather than deal with you".

Nonurgent patients seldom expressed displeasure or dissatisfaction with their care or treatment by a member of the health care team during the time they were being treated. This may be the result of feeling too vulnerable at that time, or that they were willing to tolerate the circumstances with the knowledge that they had the option of either leaving

the Emergency Department at any time, or deciding not to follow the prescribed treatment. The majority of the nonurgent patients interviewed, did however express concerns about the care provided to them during the second interview, when they were at home. When asked if they had spoken with the staff if they were concerned about the way they were being treated, the patients denied confronting anyone during their care.

Two of the urgent patients felt that members of the health care team would occasionally react to the patient's disagreement or attempt to take control over their treatment by becoming frustrated and angry with them. Similar to the nonurgent patients, urgent patients felt the staff at times would talk abruptly to them. "They treat you rough, some of those nurses. Bark at you, that's the worst of it". These same patients talked about the use of avoidance by the staff, as a form of punishment. "They just go away, that's all". Another patient felt that once she was labelled as a "bad" patient, she was avoided, "Because I have the feeling that I was a bad patient, bad patients get isolated, they get left alone. And it seems after that, they're (the nurses) a little less quick to answer if you ring for something or you need something. Now, it could simply be a perception on my part, I'm not saying they <u>are</u> doing that, but...that's what it seems like. It could be another (form of) isolation".

One patient identified how the experiences of childhood influenced how she initially related with physicians. She was brought up never to question any physician, "I felt like I had no choices, I felt that and my parents brought me up this way. That this is the doctor. You're the patient, the doctor knows more than I do so ... listen to the doctor, and that has got me into a lot of trouble". The influence of such childhood experiences made it very difficult for this patient to question or get involved in decisions concerning her care. The only way in which she began to overcome this barrier was through her experiences with members of the health care team, and by searching for a physician who could acknowledge her need to maintain control over decisions in her care.

Whereas nonurgent patients did not seem to confront the physician and nurses to discuss their concerns regarding their treatment, the urgent patients tended to be more assertive with the staff. The patients referred to the process they underwent in becoming more assertive as a "change in attitude". "I just tell 'em right back. That's the way to be now". Past experiences resulted in urgent patients perceiving a need to exert more assertive behaviors. "Yes, I had to change. There are some days where I look at myself and I don't like the way I behave towards some nurses and doctors. It's the fear getting in the way of, ... what they're trying to do to help me, but it's my fear compounded over all the experiences that causes the biggest problems".

The urgent patients' past experiences influenced not only the patients' perceptions of their care, but also the patients behavior on subsequent visits to physicians or admissions to hospital. For those urgent patients with chronic illnesses, past experiences provided a frame of reference when patients were assessing their illnesses and deciding whether to seek medical attention, and which source to utilize. Past experiences were very influential in not only guiding the patients' decisions in selecting health care services, but also in changing patients' behaviors when the individual assumed a patient role.

Choice of Hospital

The choice of hospital for urgent patients was determined primarily by where the patients' family physicians admitted. Since two of the urgent patients expressed great confidence in their physician's capabilities, they would not consider going elsewhere for medical treatment. One of the patients discussed that the only time she would insist on changing hospitals, was if the care was exceedingly poor, or she became very frustrated with the care. At this time she would leave and go elsewhere. "I was calling my doctor and telling him he had three choices, he gets me a room in the hospital, he gets me into

that room, or he gets me into another hospital. I didn't care, I didn't care which of the three he chose".

The selection of a hospital where a patient would seek medical assistance was influenced by past experience. The elderly man from a rural town had been referred to another hospital within the city a few years previously, but he had a very negative experience during his hospitalization there. As a result, this patient refused to go there for treatment and arranged for subsequent admissions at another major facility in the same city.

Convenience and proximity were generally not a factor in a choice of hospital. Only one urgent patient discussed the fact that he went to the closest hospital since he had no means of transportation. Unlike the Native nonurgent patient, who could arrange with Social Services for transportation to sources of medical assistance, the Native urgent patient mentioned that his Social worker would not pay for any form of transportation to a physician other than an ambulance to an Emergency. In such a situation as his, therefore, proximity of a hospital was critical.

The patient whose husband was a physician, considered it important to be admitted to a hospital where not only her family physician had admitting privileges, but also where her husband worked. She was comforted in knowing that if she needed to see a specialist at any time, several specialists, who were also her friends, would be caring for her. "It's really nice to go to people you know, I find it very comforting. Some people are self-conscious about that, but I'm not".

Expectations

Urgent patients' expectations of their care were similar in many ways to those of the nonurgent patients interviewed. There were differences, however. Unlike the

nonurgent patients who focused primarily on being seen "quickly", the urgent patients main priority was the relief of signs and symptoms so they could continue with their normal lifestyle. "The usual expectation I guess...and the most important one is that the medical problem will be looked at". When the urgent patients were experiencing pain, they expected to be relieved of their discomfort as soon as possible. Generally, urgent patients had made several attempts at home in an effort to relieve their pain, so that be the time they chose to go to Emergency, they were in a fair amount of distress.

Seeking medical assistance had a much deeper meaning for urgent patients, one that involved added worry over a condition becoming more acute and requiring additional treatments, which, in turn, might alter their lifestyle. Urgent patients used the knowledge gained from previous visits as a gauge to assess how ill they were and what the implications might be. If the last time the urgent patient was admitted with similar symptoms, which had required a two week hospitalization, the knowledge of this experience, was often even more distressing for the patient.

Although nonurgent patients discussed past experiences when they believed the legitimacy of their illness and seeking medical assistance was in question, the urgent patients generally seemed to have much less difficulty or doubt from members of the health care team, regarding the severity of their illnesses. A possible explanation for this may be that two of the patients changed family physicians until they finally found one who did not doubt the patients' assessment of their illness or belittle their concerns.

During previous experiences, one of the urgent patients felt the legitimacy of her illness had been questioned. This patient, with a chronic illness, was not only doubted as to the legitimacy of her visit to Emergency, but also told that she was "wasting the physician's time". She commented, "One doctor told me when I felt that I was tight (asthma), that I was not tight and I was wasting their time". Such experiences, similar to those verbalized by the nonurgent patients, resulted in this particular patient delaying

seeking medical assistance until there would be no doubt by any physician as to the legitimacy of the visit and the severity of the illness. "So now I've tried to stop myself from doing this but I'll wait until I'm really bad before I'm going to walk in the door (of the Emergency Department). Now usually when I come in here with an asthma attack, I'm to the point where I can't talk anymore".

This same patient discussed situations when she felt there was doubt expressed by nurses regarding the severity of pain she was experiencing. "They're (nurses) frustrated at me because I can't deal with my pain. I've been told to my face by some nurses that, "The pain can't be that bad". These types of responses not only negated the patient's feelings, but belittled them, resulting in hurt and angry feelings.

Both urgent and nonurgent patients expected to wait for treatment in the Emergency Department. Nonurgent patients expected to wait to be seen, while the urgent patients knew from past experiences that the majority of their time spent waiting would be for an inpatient bed. Just how long both the urgent and nonurgent patients were expecting to wait was based on their past experiences in the Emergency Department.

The most difficult period of waiting for urgent patients in the Emergency was waiting in the hallway for an inpatient bed. Patients felt ignored by the Emergency nursing staff, acknowledging that the staff were busy, yet feeling very isolated. "Sometimes a nurse has to be there doing whatever,...and they won't look at you in the eyes, or, ... they've asked me to sit up and they'll back away almost out of the room and then come forward and do whatever they have to". Patients expressed concern that they did not know how to call a nurse if they requested assistance. "You can't call anybody (Emergency nurses)...I couldn't get up or down out of that stretcher on my own". "It would be more helpful to still have that contact with staff, with nurses. To continue to check, just have that conversation now and again, it would make you feel like you're still there". One patient acknowledged that even though she had seen patients in the hallway

on previous visits, until she experienced it herself, she really couldn't believe how uncomfortable the experience was. "I think it was good for me to be in the hallway, because I honestly, when you see...the pictures in the paper...it was unpleasant in that way. I think some of the politicians...could stand an hour or two in Emergency and they might appreciate it".

Physically, the urgent patients found the hallway very drafty, noisy, impersonal, and lacking any remote sense of confidentiality. "It's drafty. It makes you feel like you're less than human, like you are of no importance". I was left out in the hall for 26 hours, I was getting depressed. I cried for two hours and no one came and helped me". For two of the urgent patients, waiting was not so much the issue, as where they waited. They felt "on display", lacking any privacy, and felt that the nursing staff tended to ignore them. One of these patients said that it almost felt as though her care in Emergency was over once she was placed in the hallway. She was almost in limbo, waiting for a bed.

The major focus of the urgent patients' expectations was reflected in their concern about the way their care was provided for them. As with nonurgent patients, urgent patients perceived the need to be respected as a vital component of the process. To the urgent patient, respect meant listening. "To be listened to. To have people (staff) say, 'Yes, you do know what you're talking about'. Rather than what I've had in the past, 'Go home, you're not sick. We can't find anything wrong with you'." Listening represented an appreciation by the Emergency staff that the urgent patient were knowledgeable regarding their condition. "I know enough to know when I'm in with my asthma, if my breathing rate is 18, I'm in trouble. I want to know that ... and often I have to fight to get that information".

Respect also meant accepting the patients' decisions regarding their care. If the patient makes an informed decision based on the additional information provided by the physicians and nurses, the patient does not want to feel belittled or sense anger and

hostility from the staff. "I've got the knowledge of my body. Let's put it together which is what I've got with my physician now and some of the nurses, so it makes it easier because I'm not continually excusing (my involvement)". "This is my body. You're not doing that, you are not going to use that instrument or do that exam or whatever". An example of not feeling respected was discussed by one patient who stated she was not even wakened before an intravenous was inserted.

> They hadn't woken me. They hadn't talked to me, and I mean IVs hurt. But that's the way she woke me up. That's not treating me with respect. I'll treat a nurse with respect unless she proves that I can't trust her and I'm the easiest person in the world to get along with as long as you respect my limits.

As with nonurgent patients, respect for one's culture reflected respect. Two of the patients acknowledged how important it was to be appreciated for their culture. An elderly male who came into Emergency as an urgent patient, felt it was very important not to feel ridiculed because of his heritage. Cultural beliefs and faith in Native Medicine and religion were also important to the Native patient. "Well, the most important thing in my mind, is respect for older people and my religion". When members of the health care team doubted his beliefs, they subsequently doubted and ridiculed him as an individual.

Caring, as evidenced by empathy, reassurance, listening, spending time with patients, and talking with them, had similar connotations with urgent patients as for nonurgent patients. One elderly urgent patient described his expectation of caring as "tender loving care", which incorporated all the previously mentioned qualities of caring. As with nonurgent patients, the emotional, supportive, humanistic elements of caring were highly valued by urgent patients. Humanistic qualities of caring were demonstrated to patients as valuing the person as a human being instead of "something that goes through the medical profession".

Reassurance was also very important to the urgent patients and their families. Since these patients came to Emergency in a more acute state than nonurgent patients, reassurance from the Emergency staff that they would be looked after and that the patients would be alright was effective in decreasing fears and anxieties regarding their condition. "I wanted...if not my mother, I wanted somebody to tell me everything was going to be fine". When information was continually provided, fears were decreased. "I can't say, "Look, I need some reassurance. I need somebody to tell me what is going on around here. Don't keep me in the dark. My mind can come up with things that you have never thought of". The manner in which the information was provided was important. It was an expression of respect if the nurse cared enough to assist the patient in understanding and discussing treatment in a language the patient could comprehend. This effort by the hospital staff in turn increased the patient's sense of security.

> She (nurse) would come in, she would talk to me, not at me or down to me, but she would talk to me and tell me this is what my (physician's) orders (were) and she'd often show them to me. You know, it was the human interaction. It wasn't, 'You're the patient, I'm the nurse. You're gonna do what I say'. So that was a big help. Just at those times, I'm often frightened and I don't understand all the medical technology".

Another patient also verbalized similar thoughts, "I like to know what they are doing and why".

When nurses spent time talking with the patients, they reflected acknowledgement of patients as valued individuals. One elderly urgent patient was very pleased with the rapport that developed with the nurses in the hospital. "Well, the nurses, have you as a patient. You're not ...a name, they know you like that. That's the main thing. When a nurse comes to you and talks to you nicely, holds you by the hand, that's what (tender loving care is)". Developing a trusting, caring relationship seemed to be very important to

another urgent patient who felt, even in Emergency it would be beneficial to have "a" nurse who looked after you specifically. Knowing which nurse was caring for the patient facilitated improved communication and a greater sense of security.

Caring was also communicated through the use of touch. For two of the urgent patients, this facilitated satisfaction with their care. "And she (nurse) would sit down with me and just hug me, that's what I needed. She saw a human being. The bad ones (nurses) have been, "You're a patient, we're treating the body". And that's often communicated nonverbally by avoidance too, not wanting to touch or be near (me as a patient)".

As with nonurgent patients, past experiences of urgent patients were extremely influential in establishing expectations of care and provided the baseline by which quality of care and ultimately the level of satisfaction was assessed. By virtue of the more serious nature of their illness or injury, the legitimacy of the visit to Emergency by urgent patients was not in question as it was with nonurgent patients. However, doubt or questioning as to the legitimacy of the degree of pain or discomfort was a concern for one of the urgent patients.

The expectations of urgent patients were not on rapid treatment or a quick-fix. Rather the expectations centered around the "quality" of care provided.

The Visit Of The Urgent Patient

The urgent patients all felt quite satisfied with their visit to Emergency. Three of the patients were admitted to the hospital, while the Native male patient had his fracture reduced, and his cast applied. Then he was discharged.

There were similarities as to how urgent and nonurgent patients evaluated their experience. Just as the nonurgent patients reflected some concern about the length of time necessary to register in admitting, the urgent patients expressed a feeling that they found

the admitting process a bit difficult because they were feeling so unwell. One patient felt very fortunate to have had her husband with her, so as to decrease her involvement in the process. "I really wasn't well, and I was grateful for my husband helping to give some of the information. When you're not well it's really hard trying to give the information...So it was helpful to have someone with me".

Nonurgent patients felt they had no control and were totally dependent on the Emergency staff as to when they would be seen by a physician. The urgent patients, however, knew that by the seriousness of their illness, they would be seen by a physician relatively soon in Emergency, but to them their loss of control was in assuming the "patient role". The nonurgent patients did not have control over the prescribed treatment, however they could leave the Emergency department and choose another source of health care. This was not the same for urgent patients who were not well enough physically to have the option of leaving the facility. The loss of control for urgent patients was more pronounced. In an attempt to gain control over the treatment of their illnesses, urgent patients were more selective in choosing a family physician. However, from the point of entry into Emergency, the urgent patients felt a loss of control and helplessness within the hospital system. They were powerless over how long they needed to wait for an inpatient bed, where they waited, and, for the most part, over decisions concerning their care. This was more apparent when the family physician was not available and the patient had to be initially treated by a physician, new to the patient.

As with the nonurgent patients, urgent patients' satisfaction was closely related to waiting. While nonurgent patients generally focused their discussions on how long they waited to see a physician, urgent patients were satisfied that they were seen quite quickly. The rationale for more expedient care of the urgent patients was based on the priority of their illness as opposed to those of the nonurgent patients. Unlike the nonurgent patients, it was, therefore, not "how long" the urgent patients waited that was a concern, but rather,

"where" they had to wait for an inpatient bed, once they had been seen by a physician. Two of the patients found waiting on a stretcher in the hallway of Emergency to be a very uncomfortable experience due to the extreme lack of privacy and the impression that they did not feel cared for by the Emergency nurses while they were in the hallway. One patient found that "a few hours of not feeling well, on public display (in the hallway), (was) interminable". This patient also mentioned that as she was lying in the hallway, an acquaintance walked by and teased her, making her feel even more awkward about the lack of any privacy. Patients waiting in the hallway also expressed feeling uncomfortable when they heard discussions by Emergency staff regarding other patients in the hallway regarding their care. This imposition on the other patients' privacy made the urgent patients concerned about confidentiality. "You feel kind of conspicuous dozing off with everybody walking up and down, and certainly the other patients that are being told one thing or another, there's no privacy". Although the urgent patients waiting in the hallway appreciated that the examination rooms were needed by other Emergency patients, they found the hallways very dark and drafty. "The hallways are dark. I wasn't feeling well enough to read anyway, but you couldn't sort of pass time in any way at all if you were there for a long time".

How well patients seemed to tolerate waiting was influenced by the urgent patients' assessment of their illness and how the patient assessed the priorities of the Emergency Department. This was evident with the Native patient who had waited in the Emergency waiting room prior to being examined. It may reflect his Native culture, but this patient's perception was that generally it's "first come, first serve", unless there is someone extremely critical. As a result of his perception, he did not make a staff member aware of how uncomfortable he was. "So even though I was in pain, I didn't tell them. I waited for a while, not that f---ing long. There was other people ahead of me". Based on this patient's perception of the priorities in the waiting room, this patient felt he waited a

reasonable length of time. Even with the wait, this patient was satisfied with the care, not only in the reduction and casting of his arm, but with the interaction with the staff. "The treatment here is good, I'm satisfied with it, they (Emergency staff) treat me good". This patient was extremely cooperative in volunteering to be interviewed and also seemed very pleased that someone would spend so much time talking with him and listening to what he had to say. It may be questioned as to whether this added interaction also influenced his perception of the quality of care he received.

Three of the urgent patients expressed great satisfaction with the nursing care in the Emergency department, prior to being placed in the hallway. "I thought they (nurses) were very nice". "The nursing care was "excellent". When patients were moved into the hallway, they felt that they were ignored, or uncared for by the Emergency staff. They expressed concern regarding the impression that "once you leave the (examination) room, you ... feel like you're finished". The patients said they not only seldom saw an Emergency nurse while they waited, but were hardly spoken to by the staff during that time. "Sure it always helps if someone comes up and says, 'How are you doing?', or, 'How are you feeling?'." The wait in the hallways with little contact with the nurses affected their level of satisfaction with the care.

Although some similarities were evident, the expectations of urgent and nonurgent patients differed. As with the nonurgent patients, the urgent patients' satisfaction with their visit was influenced strongly by past experiences. What the care was like in the past, and how long they had to wait the last time they were admitted to hospital, affected how satisfied the urgent patients were with their current visit. If medical and nursing care was provided more quickly during this visit the patient expressed greater satisfaction.

Both the nonurgent and urgent patients entered the Emergency Department with the expectation of receiving competent knowledgeable care. Satisfaction with the quality of care however was very closely associated with the interpersonal relationship established

between the staff and patients. A closer relationship between the Emergency nurses and patients was facilitated through establishing a rapport with one Emergency nurse in particular. This was perceived as an opportunity for more personal, individualized care.

Summary

The comparison between nonurgent and urgent patients' experiences in Emergency revealed both similarities and differences. The underlying meaning patients attributed to their decision to seek medical assistance through an Emergency Department differed between the nonurgent and urgent patients. For nonurgent patients, the decision to seek medical attention in an Emergency Department meant convenience and a "quick-fix" to health concerns. Urgent patients' decisions to go to an Emergency Department, generally involved a perception of fewer options available to the patient, either due to unresolved pain, an increase in severity of a chronic illness, or an injury which required quick medical attention. This decision had little or no consideration of convenience, but rather was based on the most appropriate source of treatment and resources.

Generally both nonurgent and urgent patients outlined a process of self-care prior to seeking alternatives for medical care. The process of self-care appeared more detailed and extensive for urgent patients with chronic or prolonged illnesses. For these patients, there was evidence that previous experience played a very strong role in their decision and selection of health care sources.

For some nonurgent and urgent patients, knowledge of resources were similar, however the majority of nonurgent patients either based their decision to come to Emergency primarily on convenience, or a quick-fix perception of the care in Emergency. For those urgent patients with chronic illnesses, it was clear that the patient's first choice of medical care would be from an established family physician who was familiar with their

illness and had developed an effective rapport with the patient. When the family physician was not available, patients perceived their only alternative was the Emergency Department. Both groups of patients clearly perceived the standard of care in the Emergency department as a source of excellence, with highly trained, competent personnel.

The influence of past experiences was apparent in both nonurgent and urgent patients. If in the past, the patients were unable to contact their family physician during particular hours or on certain days, or had difficulty obtaining an appointment quickly, they more rapidly sought other alternatives. Past experiences for both groups of patients also served as a form of comparison by which they would evaluate the quality of the care provided to them. For nonurgent patients past experiences influenced not only their decision-making process, but very strongly affected how quickly they perceived their care was given. Past experiences were also influential for urgent patients in seeking the source of medical assistance, as well as in establishing expectations of care. Although both nonurgent and urgent patients expected competent, safe care in Emergency, nonurgent patients also included rapid treatment as an expectation. Urgent patients' expectations focused on "how" their care was provided to them. Satisfaction with care for all patients was closely associated with the quality of care.

All patients expected to be believed by the Emergency staff that they were ill and that it was not necessary to further legitimize their decision to seek health care. Nonurgent patients appeared to have the greatest difficulty with legitimacy in the Emergency Department and they expressed great concern as to the impact of this doubting by the staff on their care and relationship with the Emergency personnel. Urgent patients, due to the more serious nature of their illness or injury, did not feel the legitimacy of their visit was in question by the Emergency staff, however, a concern was expressed by two

patients who felt the degree and/or severity of their discomfort or symptoms was doubted at times.

The choice of which Emergency Department to visit was strongly based on proximity to home and convenience by nonurgent patients. If nonurgent patients had an established family physician, their decision might be influenced by where the family physician had admitting privileges. The majority of urgent patients' choice of Emergency Department was based on where the patient's family physician had admitting privileges, and where the patient's previous health records were located. Previous experiences of having received care from the Department was also an important influence for urgent patients in selecting a hospital.

The Visit

The "visit" to the Emergency Department was influenced by three key elements: The setting or environment of the Emergency Department, patients' expectations of care, and the staff working within the Department. These factors ultimately determined the patients' satisfaction with the care provided, as well as, the meaning nonurgent patients attributed to the experience.

Staff"s Perception Of The Visit To The Emergency Department

The nonurgent patients' perception of their visit to the Emergency Department was influenced by the physical and organizational environment of the Department, past experiences of coming to an Emergency Department, expectations of care, and the verbal and nonverbal communication with the Emergency staff who delivered care to them. Emergency staff had a significant impact on how patients perceived their care. To gain an

understanding of the staffs' beliefs, perceptions, and behaviors, four Registered Emergency Nurses and two Emergency physicians, all with varied years of Emergency experience, from a few months to several years, were interviewed for one to two hours. Discussions with the staff addressed three main issues: staffs' perceptions of the utilization of the Emergency Department, their beliefs regarding nonurgent patients, and the impact of nonurgent patients on the Emergency Department.

Utilization of the Emergency Department

The Emergency staff interviewed identified a transition in the acuity of patients who have come to the Emergency Department over the last 10 to 12 years. They noted that since that time, a very high volume of nonurgent patients utilized Emergency as a source of medical care. At the same time, the acuity of patients in Emergency has become higher, with a lengthened stay in the Department. Consequently, there is a drastic increase in the amount of diagnostic tests and nursing care required to accommodate to this change.

> We do so much more for the patients in Emergency, whereas before, ...a trauma (patient) would come in and be stabilized, we'd do the initial interaction and then they would be sped off to ICU. Now what we're doing is we're holding patients and maintaining those patients for so much longer. It is not unlike Emergency to hold an intubated patient for up to ten hours, depends on what the course their treatment is or because ICU is not able to accept the patient or able to accommodate the patient because of space.

The impact of providing more detailed, comprehensive Emergency care had significant implications on the workload of the Emergency staff. "We're seeing sicker patients, I think in the last five years than we saw in the first five. Our admission rate has

gone up roughly from 10% to close to 20% so we're getting sicker people, we're admitting more, and our volume's come down so we have a higher percentage of patients that need to be hospitalized". A greater number of urgent and emergent patients were admitted to the Emergency Department with approximately 60% of the total patient volume continuing to be for the care of nonurgent patients. There was a belief expressed by one of the Emergency physicians that ideally, 60% of Emergency patients should be urgent, however, this has not been the case, and may in part be the result of the proximity of the hospital to the inner city. The increase in violent crimes and the effect of changing societal pressures has also affected the Emergency Department. "I think...because of inner city violence and of course, we see a lot of sick patients from there (inner city), whether it be an alcoholic, the alcoholic ends up with the subdural, or the stab wound or the gun shot. But on the same token, because of the inner city location and the lack of sort of physician support in the inner city, they end up coming here (Emergency Department) for their care".

With the increased acuity of patients, the staff expressed the concern that there had not been a proportionate increase in the number of Emergency staff. "The number (of staff) on the floor or available...There may be less on some days when people are sick and we don't replace. Yet the workload,...the workload is significantly heavier, not only the type of patients, but the way we're treating patients has changed. The number of patients that receive sort of intervention therapy,... IVs, intravenous drugs, the antibiotics, the older patient that sits around for many hours for rehydration".

As a result of the transition in the type and acuity of Emergency patients over the years, the staff believed their workload had also been influenced. They found it necessary to focus their efforts more on the urgent and emergent patients, still recognizing that the percentage of nonurgent patients coming to the Emergency Department was approximately 50 - 60%. The changes in the utilization of Emergency influenced the

Emergency staff. They felt more torn when they were spending time caring for nonurgent patients, feeling they should be focusing more of their efforts to care for the large number of urgent patients. "I think they (nonurgent patients) get their care but I think the people feel that they're robbing Peter to pay Paul here. They're spending an inadvertent amount of time on nonurgent patients who are simply demanding the time because they have totally misread their problem. When you (staff) feel the pressures of being with a sick person, who's waiting because you're dealing with this non-sick person". As a result of the increasing demands on the Emergency staff, one physician discussed the effects on the staff. "I think the staff are drained. I think that what happens is, it's another thing that staff have to cope with. As a result they end up in conflict, usually 'cause they view this (nonurgent) patient as a person that shouldn't be there. When they're caring for people that should be there, they view this (nonurgent) patient as stealing time from them (urgent/emergent patients). So you get perfect ingredients for a conflict, and there is conflict, and we know all the time that there are complaints that come about the hospital because this person wasn't treated appropriately, or a comment was made".

The benefit of having the mix of patients to include nonurgent was also viewed by one physician as providing a bit of relief in a system which otherwise would be extremely stressful. "I think psychologically,...if you only looked after the acutely ill patients constantly, I think you'd burn out very fast because of the stress load. I think that the walk-in (nonurgent) patients buffer the whole (system), the peaks and valleys. So when it is quiet, you've still got other work, other workload to be done. When it's busy, those nonurgent patients wait anyway".

The staff had noted a transition over the last 10 to 12 years in the utilization of the Emergency Department. The increase in the number of patients and the heightened acuity had significant implications on the workload. These changes have necessitated the provision of even more detailed, comprehensive Emergency care. Since no additional staff

had been added to the Department, the staff were feeling a greater need to focus more on the needs of urgent and emergency patients. Caring for nonurgent patients made the staff feel frustrated that they were being "pulled away" from patients who were desperately in need of their care.

Emergency Staff's Perception Of The Nonurgent Patient

The definition of a nonurgent patient varied among the staff interviewed from "someone who really shouldn't come to the Emergency Department" to "a patient who did not require medical intervention for more than 24 hours". The discrepancies within the range of definitions reflected the subjective element that existed in classifying the nonurgent patient. There was more consensus noted between the staff when they defined urgent and emergent. Subjectivity in defining nonurgent patients was also apparent when the staff were asked to approximate the percentage of Emergency patients they believed were nonurgent. The percentages discussed by the staff of nonurgent patients in Emergency, ranged from 40-80%. From these discussions, it seemed apparent that how the staff defined nonurgent affected who they categorized in this nonurgent group, and how much the staff believed this group influenced the Emergency Department.

Whether staff viewed the numbers of nonurgent patients increasing over the years was also influenced by their definition of "nonurgent". While some felt there seemed to have been a bit of a decline in the numbers of nonurgent patients throughout the last few years, others did not. There was consensus, however, in the concern that the nonurgent group deterred them from providing nursing care to the urgent and emergent group of patients in Emergency.

The staff's discussions regarding what they perceived to be characteristics of the nonurgent patient were consistent. All staff focused primarily on the nonurgent patient as

someone of low socioeconomic background, living in close proximity to the hospital, with limited means of transportation, who is less educated, "probably not employed", on Social Assistance, a "repeater" in the Department, unable to assess the illness, lacking confidence in their own judgement following their assessment, lacking knowledge regarding health care resources, and seeking instant gratification or quick improvement.

Generally nonurgent patients are perceived as more demanding than either the urgent or emergent patient. "I know my bias again, I don't think that they (nonurgent patients) even really belong here perhaps and therefore when they say, 'Gee, when am I going to be seen', or 'This (waiting) is upsetting', or 'I've waited so long'. I think they're as equally demanding as the other two and in fact may be a little more so, because they're the one's that are able to walk around and come up (to the Emergency desk)". "The patients that are usually the most demanding are usually the patients that don't need to be here, in my opinion. They're grossly overstating their problem and often times come in belligerent to begin with. They come in with a chip on their shoulder before they even come in".

There was a diversity of beliefs expressed regarding the nonurgent patients' knowledge of resources and selection of health care services. Staff also recognized the difficulty for a number of the residents of the inner city, in reading and/or the accessibility to written information regarding resources. Generally the nonurgent patients were only aware of, or felt their only alternative in seeking medical attention was the Emergency Department. The effect of a larger immigrant population in the vicinity of the hospital was apparent to the staff. There were feelings of frustration, however, when a patient unable to speak English came into the Department without being accompanied by a translator. This led to delay in treatment when there was an inability to communicate. It was perceived by the staff that people new to the country were informed by others that there were translators available in the Emergency Department. It was recognized that the availability of a family physician who could effectively work with these people was

decreasing. "I think we're seeing more and more (non-English speaking immigrants). They don't have the other resource of a family physician that can speak their language or that are willing to put in the time to communicate with them and I think a lot of people end up coming to Emergency. We have good access to interpreters through nursing and some physicians, housekeeping...so we can usually...find an interpreter for whatever language or dialect there is and that certainly helps with communicating with the patients and getting information back to them as to what's happened".

Generally the Emergency staff perceived nonurgent patients' rationale for accessing medical assistance through the hospital system primarily one of convenience, the need for "instant gratification", or a "quick fix" in getting better. Patients' lack of utilization of a family physician or a Medi-Centre was of concern to the staff. Nonurgent patients were often perceived as not having a family physician, and if they did have one, they made limited attempts to even try to make an appointment because they were not prepared to wait. The unavailability of family physicians due to limited office hours was recognized as a deterrent. Difficulty nonurgent patients experienced in establishing a family physician was apparent when patients were given the name of a family doctor during a previous Emergency visit only to be refused an appointment when they called that doctor's office. "I have had patients...seen in Emergency once or twice and were told, 'You can use this Doctor as follow up or, any other problems that you may encounter. You may see this doctor', ...and I've had the occasional ones that have phoned back for another doctor's name because they have tried to get into the clinic and that clinic is not receiving new patients". As a result, the next time the patient was in need of medical assistance, it meant another trip to the Emergency Department. It was also perceived that some patients, regardless whether they were given a referral card to a family physician, would continue to utilize the Emergency Department in place of a family physician. "The next day, or a week later, that same patient may come back in and he has gotten Dr. X's card, but now

he will get Dr. Y's and he will add, some patients, believe it or not, have a collection of Doctor's cards that may never go back to see those Doctors but continue to use Emergency".

One of the Emergency physicians expressed a concern that a number of family physicians add to difficulties in access by establishing their office hours for their convenience only, not for the convenience of their patients. "Now many physicians are going into medicine for lifestyle and they're making lifestyle decisions on how they're going to practice and the answering service is on at five o'clock and there's a total stranger taking calls for a large group. The patients want to have access to their doc.". Due to this inability to access their own physician, patients are left to seek other alternatives. "The family doctor has moved further and further away from the family". Since the family physician is most often not available on weekends, this also affects the patient and "patients (were) basically indirectly being forced to find other means". One of the most likely sources of obtaining medical assistance then became the Medi-Centre, which sought to "fill the gap" in accessibility to medical care.

> Well they've (Medi-Centres) made a difference but they've made a big difference to G.P.s not to us (in Emergency). They've taken some of the cream off the top and not cream, but the quick snappers and that's fine but you know that's funny. The G.P.s made themselves non-available, the Medi-Centre came around to fill the void. Now G.P.s are bitching that Medi-Centres are taking the easy stuff. Well, I'm sorry if you're not available, people are going to do this.

The staff's frustration with the present health care system and access to health care services extended to the use of Medi-Centres and their impact on the Emergency Department. Although some of the staff felt the advent of Medi-Centres had somewhat relieved the Emergency Department of some of the nonurgent patients, other staff members did not agree. A large number of the inner city residents were not aware of what

a Medi-Centre was or where it was located. "Sometimes you have great ideas (Medi-Centres), and think it's going to solve your problems (in Emergency) and it doesn't. Just like Medi-Centres, I have patients coming in and they've had bad experiences and like, they've tried to go the correct route".

Staff recognized that Medi-Centres filled a gap in access due to the flexible hours of operation. There was some resentment expressed when patients went to a Medi-Centre and later also came to the Emergency Department either to verify the Medi-Centre's findings and treatments, or to seek additional medical assistance because the patients did not perceive they were improving. "I think Medi-Centres are a leech quite frankly".

Limitations of Medi-Centres such as not consistently seeing the same physician, as well as, the limitations in providing care were discussed. "So they (patients) go to a Medi-Centre, it's convenient, but again they got the problem of the doctor shuffle, some of them don't do x-rays, none of them put casts on, so the system gets billed by the doc in the Medi-Centre for seeing the patient, doesn't do anything, then sends them (patient) to the (hospital name) to be cared for. So then we try and bill, we don't collect because we, you can't bill twice for the same problem. So the patient comes to us, we provide the care, put the cast on, set the fracture...Medi-Centre guy gets paid". This scenario was further aggravated when often times physicians from Medi-Centres themselves would see patients, then "refer" them to the Emergency Department, for diagnostic tests or additional support which could not be provided in the Medi-Centre. These situations resulted in Emergency not being able to bill for the care of the patient. When such a situation occurred, the current health care billing system was perceived by the staff to be a detriment to the Emergency Department.

The nurses and physicians discussed their belief that the Emergency Department represented the ultimate in access, convenience, quality of care, and speed of treatment. "They (the patients) haven't had time to make an appointment or it wasn't convenient for

them to see their own doctor, so they will drop in Emergency to have it checked or else a patient that does not have a doctor and they don't know where to go , so they come to the Emergency Department". Staff perceived that patients had a great sense of confidence in the competence and capabilities of the staff. "I think...for whatever reason, the hospital, patients expectations when they come to the hospital I think is much greater than if they showed up at a family physician or a Medi-Centre". "My perception is that most people feel the Medi-Centre is a quick exam or check and if there's really anything wrong then they'll end up going either to the family doctor or to Emergency. And if it's an acute problem, then they'll (the patient) end up coming to Emergency". The Emergency Department also represented a last resort for patients when other sources of medical care were either not available or not perceived to be of a level of quality the patient felt they needed. "Just the fact that it's a hospital and its an Emergency they often, we'll often see people that have been to their family doctor or they've been to the Medi-Centre and they're still having troubles so their last resort is to come to the Emergency hoping... that they're going to find an answer". "Sometimes Emergency is used as a second opinion". "The G.P.s have made themselves not available in the evening and some people are finding that Medi-Centres aren't all they're cracked up to be therefore, the only other alternative is to come to Emergency". When the family physician was not available in the office or as readily accessible as the patient desired, they would seek care through a hospital. Although Medi-Centres were seeing a number of nonurgent patients, the patients' concerns about quality of care and accessibility, resulted in the Medi-Centres not always being the ideal back-up to "fill the gap" in the health care system.

Concern was expressed as to the ability of Emergency Departments to meet the needs of nonurgent patients. There was a sense among all the staff interviewed that given the deficiencies in the health care system they were prepared to meet the needs of nonurgent patients when appropriate such as on nights, weekends, and holidays. Concern

and frustration was expressed, however, when the staff perceived that no effort was made by the patient to even attempt to contact a family physician or Medi-Centre and that patients were utilizing a very expensive source of health care "in place of" a family physician.

Inappropriate utilization of the Emergency Department by family physicians who directed their patients to either meet them in Emergency or to be seen by an Emergency physician was viewed as abuse of the Department. The staff felt that when this occurred, the physicians were educating patients as to the inappropriate use of Emergency. "Well, doctors,.tell their patient, "Just go to Emergency, because he's (the family physician's) at home now. I don't think physicians teach their patients what to do. So they (patients) go to Emerg".

Feelings of frustration with the family physician was also evident when the physician would send the patient to Emergency with a list of instructions for the Emergency staff to complete before the family physician would meet the patient in Emergency. This not only served to educate the patient that this was appropriate use of the Emergency Department, but also that the next time patients were unable to contact their physician, and perceived that there would be a need for diagnostic tests, they could go to the Emergency Department for diagnostic tests.

The staff recognized that inadvertently their frustration with the family physician was, at times, inappropriately directed towards the nonurgent patient. "These (situations) are frustrating and ...unfortunately, ... I have transferred my feelings from not so much the patient, I am not angry at the patient, I am angry more at the Doctor for doing this or for them having an expectation of Emergency to do this. I have to stop and say to myself, 'It's not the patient's fault'. The patient was only following the directions of his physician. It's human nature..that those feelings spill over from what your feeling towards the doctor is and how it influences the care you're going to give the patient". It was clear that even

though the staff could get frustrated with these types of situations, they did believe that the person who improperly utilized the Emergency Department, and "the biggest culprit", was ultimately the family physician. The patient in reality was "caught" in the middle. "Now I know doctors will send the patients in and that's probably more upsetting because then patients are given the wrong information. They're under the impression they're either going to be admitted or get this and this and this done. They're not, and then they get upset because they have to wait their turn and Dr. so and so isn't going to meet them".

The Hospital had an "open door" policy and could not refuse treatment to any patient who sought medical care. There was a sense of total loss of control among the staff interviewed. They felt helpless in trying to provide effective and efficient quality care to all patients. As a result of the policy, it was not perceived by the staff to be appropriate to refer nonurgent patients to a Medi-Centre or their family physician, or that they refuse to treat nonurgent patients when they came to the Emergency Department. The staff's sense of powerlessness would at times be expressed as frustration towards the nonurgent patients, particularly when the Department was extremely busy with urgent and emergent patients. Both nurses and physicians discussed occasions when they tried to educate the patients as to more effective and appropriate decision-making in terms of health care resources. One of the nurses related an instance when a middle-aged man chose to come to Emergency for a wart on his finger and the nurse's need to assist the patient in recognizing alternative sources to medical care and/or appropriate self-care methods. "I had a guy with a wart the other day and we (Emergency staff) have a responsibility for teaching these people. I said, 'You call this an Emergency?....This is an Emergency ward, we treat life threatening Emergencies here. You will be seen but I want you to know that could have been treated at your doctor's office or at a Medi-Centre, and next time, can you remember that?' I make it clear that they shouldn't be here, but I also make it clear you (the patient) will be treated". From this example, rather than educating the patient,

the nurse's level of frustration was reflected towards the patient which may have resulted in the patient feeling intimidated and reprimanded by the nurse.

Convenience of coming to Emergency was discussed in terms of ease of access to medical attention. While the staff expressed some frustration with the nonurgent patients "use" of Emergency, they all addressed the fact that they did recognize that in the patients' eyes, their concerns were not always minor to them.

> Certainly some people will use Emergency because of the convenience because they know the physicians, or like the physicians, they've had positive experiences before. A lot of what we call nonurgent problems in the patients mind, patient's perception, is not nonurgent, especially at the time and it's perhaps, once they're seen, diagnosed and explained, ...then they can appreciate it wasn't really that urgent to come at the time. But at the time, when they make the decision to come, and I don't think we can fault them.

The staff's comments were followed by empathic comments regarding patients' perceptions of their illness and their lack of skills with which to assess their illness. Another area which one of the staff identified as a difficulty nonurgent patients faced was the lack of support from significant others and assistance at home in the decision-making process of seeking health care. "I don't think,.... in the past, the resources that people have at home nowadays compared to years past aren't nearly as good that they can make the decision, they don't have the other family members around, or grandparents, whatever, to give feedback as to their conditions".

The staff identified the effect of previous experiences in Emergency as influencing future decisions in seeking medical assistance. Some patients were seen to come to Emergency as a force of habit. They came in the past and were pleased with the treatment and would subsequently continue to utilize the Department for future health concerns. "They (nonurgent patients) haven't said, but I can (tell) that it's a habit, you know they've

done it before (come to Emergency), or that that's where their friends go. You can tell on their chart how many visits they've had, so it's a pattern that works for them". From these discussions, it seemed that there may be the possibility that the Emergency staffs' perception of the nonurgent patient may be influenced adversely by the knowledge that the patient had not only utilized Emergency several times in the past, but was utilizing Emergency physicians as family physicians. Therefore some of the staff came to the conclusion that the nonurgent patient was "abusing" the Emergency Department.

It seemed that particularly when the Emergency staff were under a great deal of stress trying to care for numerous urgent/emergent patients, that trying to be understanding and empathic to the needs of anxiously waiting nonurgent patients was frustrating to say the least. "Well, they're (nonurgent patients) demanding, they're usually the one's that are up to the front desk at least a half a dozen times demanding they be seen right quick because they're sicker than everybody else. Because they've got so much time on their hands, and obviously they're using the Emergency for convenience. They've got things to do and places to go". Emergency nurses felt pressured by not only the constant heavy workload and demands of the unit, but by the requests of nonurgent patients to be seen quickly. Consequently, the demands of nonurgent patients were resented.

For some of the staff, nonurgent patients presented both challenges and opportunities for patient/family education. "A lot of our clientele come with extra baggage and by that I mean social issues are a major problem". These nurses expressed interest in seeing the patients' visits as a time to include health promotion information and additional support, particularly to the patients from the inner city who may not utilize any other source of health care. For other staff, caring for nonurgent patients was viewed as unchallenging, and wasting the advanced Emergency skills the staff had developed. "It (nonurgent patients) bothers me, I think it's a waste of my skills and the skills of the people that I work with. That's sort of my professional attitude".

All of the staff felt the proximity of the hospital to the inner city core predisposed the Emergency Department to utilization by a large number of residents from that area. Others disagreed. One Emergency nurse expressed her belief that "in other hospitals located in 'white collar areas' you're going to see the same abuse and you might even see it moreso... So then it isn't just intelligence, this whole society is based now on convenience, (and) rapid access".

The staff identified an important advantage of the Emergency Department, that of rapid accessibility to specialists and/or referrals. The staff felt that as a result of the current system of delayed accessibility to specialists, all patients, in particular, nonurgent patients perceived this as a quick route to specialized medical care. An area not alluded to by the nonurgent patients, but believed by the staff to be another reason why patients came to Emergency, was for more rapid and easier access to Social Service programs. "I think our Social Service program in Emerg. has been just so excellent with outreach that people (nonurgent, inner city residents), if they view a problem that they think can be handled by Social Services, that's their way of plugging themselves into the system without going through the social worker and waiting two months". It was evident that the Emergency was perceived by staff as not only the entry point into the health care system, but also as a means of trying to work through faults or deficiencies of "the social service system", external to the health care system.

Difficulties with accessibility to appropriate medical assistance addressed by the Emergency staff was inappropriate utilization of the Emergency department by nursing homes when patients were sent by ambulance for a very minor condition, such as reinsertion of a gastrostomy tube or a blocked foley catheter due to an unavailability of the patient's family physician or someone on call. "And rather than have the doctor come over and put it in, they (nursing home staff), put them in an ambulance, send them to Emergency, and we put it in". Two issues were of concern to staff, the first being the

impact of added expense on the health care system for transportation by ambulance and an Emergency visit, and secondly the implication for the elderly, that is, sending them into an unfamiliar setting when they were often confused and disoriented. Concern was also expressed about the additional nursing time required to comfort and reassure the patient as well as care for their other medical needs, such as administering insulin if they were diabetic. "If they're a geriatric, medicine patient...they're confused, they might be yelling, singing in the hallway, and then you get some tempers rising (of other Emergency patients)". From these discussions it was evident that although the patient entered Emergency with a nonurgent health concern, he/she ultimately may require a great deal of nursing care during their visit, with subsequent impact on the workload of the nurses. "So between health care institutions, we're not utilizing the Emergency for nonurgents (patients) the smartest way we could (be)".

One of the nurses felt that caring for medical patients from nursing homes, the turning, feeding, and changing due to incontinence not only resulted in taking the nurses away from caring for more acutely ill patients, but was not what she anticipated as the role of the Emergency nurse. "And those nursing home ones are heavy care, they are incontinent, they need feeding, Oh God! If they were there over a meal time. The other day I was feeding someone and I said to a colleague, `Do you know, I really thought I got out of this for good, but there I am, feeding someone his supper'. From this statement it was apparent that the individual nurse's perception of the role of the Emergency nurse strongly influenced how the nurse viewed the various types of patients coming to Emergency.

All staff recognized that nonurgent patients were labelled at times, as unmotivated in seeking other sources, abusing the health care system, or "leaching off the system". This labelling by the staff occurred most often when they were busy and trying to cope with the urgent and emergent patients in the Emergency Department. The knowledge

from the Emergency chart that patients had visited Emergency several times added to the staffs' identification and labelling of these patients as "abusers" of the system. "I would be frustrated about these patients that you see that they've come 142 times with ear aches and you know you see beyond that condition and you try to understand the reasoning behind it. It's not the ear ache, it could be a lot of different reasons why that patient's here. I think we sometimes react to what is stated on the chart...and we tend to label people and that's unfortunate because I think every time a patient presents himself is a new occasion."

The other aspect of labelling of nonurgent patients by the Emergency staff focused on how "ill" the staff viewed the patient. When a patient did not "appear" to be very ill, seldom did any staff discuss with the patient, what their perceptions of their illness was, nor did they generally ask the patient why they decided to choose Emergency as the route to medical care. Often the labelling was initiated just from seeing the admitting diagnosis, at times without even talking with the patient to obtain further information. How negatively the staff would label these nonurgent patients was influenced by how busy the Emergency Department was, how "ill" the patient looked, how "demanding" the patient was (as perceived by the Emergency nurse) and the time of day. If the patient looked "well" to the Emergency nurse and came during the day, when physician's offices were open, this would often negatively influence the nurses' perception of the patient. On the other hand, if the patient "looked ill", and arrived in Emergency at 0300 hours, the staff could more often appreciate that the Emergency Department was the patients' only alternative and that they must be needing medical assistance to come during the night.

Three of the four staff nurses commented that if the patient stated he/she had attempted to go to a family physician and could not be seen for at least a day, this would generate greater understanding and acceptance of the patients' decision to come to Emergency. The staff were very negatively influenced and would quickly label patients as "demanding" when they would arrive in the Emergency Department and request to see

their own family physician. If patients had not contacted their physician prior to coming to Emergency, they may be required to wait extended periods of time. When the patients verbalized impatience with the wait and their frustration regarding the "slow treatment" they were getting, the nurse likewise expressed frustration with the patient. At times a minor confrontation could occur between the nurse and nonurgent patient. The nurses all felt they were more prone to doing this when the unit was extremely busy. "It depends on what the activity of the hospital and the Emergency Department is too. If it's quiet, then everybody gets pushed through right away, whether you're just a scratch or whether you just yawned. So it has to do with the environment". When discussing these situations during the interviews, two of the Emergency nurses expressed having had a feeling of guilt when they had been abrupt or harsh with some of the nonurgent patients, but they felt their reactions were influenced by the situation on the unit as well as the nonurgent patients. The result of conflicts such as these not only generated a sense of guilt among the Emergency nurses, but also decreased their job satisfaction.

Legitimacy of nonurgent patients utilizing the Emergency Department was discussed by the staff in terms of the funding of the Emergency Department. From the physician's perspective it was necessary to treat a certain number of nonurgent patients in Emergency for the purposes of ensuring adequate government funding for the unit. Since the advent of Acute Care Funding, numbers of patients influence the distribution of funds. The Emergency staff estimated that approximately 40-50% of the total patient volume was nonurgent, the loss of this large number of patients would subsequently result in a drastic decrease in funding. "You have to have a certain underlying volume that comes in the door to provide an income such that we can provide the other care to the more complicated ones. If it was just sick, sick, sick patients that came in every time the fee schedule the way it's set up right now wouldn't pay. We wouldn't get paid for those patients". The result of a decrease in nonurgent patients, would lead to changes in the

allotted budget of the Emergency Department and greater difficultly in providing adequate care to the urgent and emergent patients.

The staff's feelings concerning the legitimacy of the visit were heightened moreso, when a nonurgent patient displayed irritability over the length of his/her wait to be seen. "Certainly there are arguments with the patients too, and I'm sure you know that there's some discussions that go on that probably shouldn't. But comments will be made at the desk or wherever, `Well, they really shouldn't be here'. It was recognized that the same amount of frustration may not necessarily be experienced by the Emergency physicians who look upon the nonurgent patient as a source of income. The nurses, on the other hand, often viewed the nonurgent patient as "abusing" the system.

Another implication of such a decrease in funding would be a proportional loss of fulltime Emergency nurses and physicians. Although the amount of direct nursing care and physician involvement is limited for nonurgent patients, there is a much greater need to not only maintain, but possibly increase the present number of Emergency staff to meet the ever-increasing demands of more acutely and critically ill patients in Emergency.

> So you eliminate those nonurgent patients out of the department, you're eliminating numbers in which case the whole process is volume driven. The operation of budgets for your department is based on volume, so all of a sudden you have less numbers, you have less money coming in, yet the patients you're dealing with now are sicker and demand more resources, but you're getting less income to provide those resources. The nursing demands go up because they're sicker people.

It was evident that the physicians, who admittedly became frustrated at times with nonurgent patients in Emergency, still recognized the importance of this group of patients, in maintaining adequate funding for the Department.

The nurses interviewed frequently made reference to effective resource utilization and "abuse" of the health care system, however none of the nurses discussed the issue of funding of the Emergency Department in relation to nonurgent patients. The focus of the nurses' comments addressed issues such as the lack of effective decision making on the part of the nonurgent patients, the inability of the patients to assess effectively their illnesses, and the lack of appropriate utilization of other resources, such as the family physician and/or Medi-Centres. "They're flu like symptoms or they're cold, or um, a lot of aches and pains that again I know the man with abdominal pain is quite recent but a number too will have these things for several days. I don't know what makes them decide to come down right now". The nurses stated that they really did not believe nonurgent patients should legitimately come to Emergency for medical treatment. With further discussion, the nurses could isolate cases when they could "understand" why the patient made the decision to come to Emergency. They also recognized that not only did the status of the unit affect their impressions of the nonurgent patient when they arrived in the Emergency Department, but also the patient's appearance and behaviors. When a patient expressed the need to be seen quickly because of another commitment, the nurses' frustration increased substantially. "Cause some people come in and say, 'Well, I've gotta be back at work by three'. They just didn't know and maybe this is the day that they get to learn how long this can take. Some days you can be called in before you've even gone back to the waiting room and sat down. And so the next time that you come you've sat for an hour and a half in the lobby, you get into a cubicle and you have another hour".

Since nurses at the main desk triages the patients and ultimately decides "when" they will assign a physician to go see a patient, the nurses' impression or belief regarding the "legitimacy" of the visit could impact on the decision as to "when" nurses would decide the patient was to be examined and treated. It is unclear how the individual nurse's definition of nonurgent influenced her decisions. All the nurses firmly believed that the

Emergency Department was the appropriate alternative for urgent and emergent patients, and that the role of the Emergency nurse was dedicated towards caring for critically ill patients.

In summary, differences were noted in how staff defined the nonurgent patient. Staff characterized nonurgent patients as having low socioeconomic status, living in close proximity to the hospital, being less educated and, most likely, unemployed. Consistent among all staff interviewed was the belief that nonurgent patients took time away from the care of urgent and emergent patients. Staff felt nonurgent patients were demanding, that they grossly overstated their problem, and that they chose to access medical care through the Emergency Department primarily out of convenience or the need for a "quick-fix" in getting better. Unavailability of physicians due to office hours and vacation were recognized by the staff as deterrents.

The legitimacy of patients' assessments of their illnesses and their decision to come to the Emergency Department were largely questioned by the staff. As a result, some of the staff recognized how labelling of nonurgent patients frequently occurred. Although one staff member perceived nonurgent patients as an opportunity for patient/family education and the use of other skills, all staff recognized that the busyness of the unit and their subsequent levels of frustration often affected the quality of care provided to nonurgent patients.

Factors such as convenience and accessibility to medical care were perceived by the staff to leave the Emergency Department vulnerable to "abuse". The abuse was not only by nonurgent patients, but occasionally by other institutions and physicians who arrange to see their own patients in the department, in place of their offices.

Impact Of Nonurgent Patients On The Emergency Department

It was important during the staff interviews to discuss the staff's perception of what it was like to work in the Emergency Department. Through this process, a greater understanding of the environment and culture of Emergency, from the staff's perspective, was facilitated.

The nurses interviewed described Emergency nursing as fast-paced and challenging. In their descriptions of the Emergency Department, staff primarily focused on the critically ill and trauma patient. It was this category of patients for whom the Emergency environment was established. The need to rapidly assess, prioritize, and treat a plethora of patient conditions with the constant pressure of time was perceived as one of the greatest challenges of the Emergency Department and necessitated not only physical, but also emotional stamina. "I'm in Emerg. 'cause I have a short attention span. I want a cross section. Call it adrenalin addict or endorphin junkie, but there's a picture of me in the encyclopedia under adrenalin junkies". "Emergency doesn't cater to one specific condition or disease process. You basically see everyone with all different, assorted problems and different types of disease processes. As an Emergency nurse, you get to learn and develop skills that go with every one of these conditions and so basically you become a master of all trades". For a number of nurses, a great advantage of working in Emergency was the belief that the Department was synonymous with quick assessment, treatment, and discharge or admission to hospital. "You get to see them for short periods of time which really is hospitalization, treatment, and discharge all compressed down into three minutes to five minutes, to an hour to four hours". "I guess maybe its the variety and it's also the pace, things happen quicker".

Not only was the fast pace of Emergency an attractive feature, but also the quick turn around of patients who were to be admitted to a nursing unit. There was a belief

expressed that in the purest form, only patients who were critically ill should be in Emergency for extended periods of time. Even when critically ill patients stayed for lengthy periods of time, the staff appeared to get more anxious and agitated. "When I found this place (I) was so delighted with it because it was an in and out type of thing". A part of the challenge of Emergency nursing seemed not only to be the care of the critically ill patients, but the challenge of caring for patients under a compressed time frame. The staff constantly confirmed their philosophy of an Emergency Department as fast-paced that challenged their knowledge and skills in caring for acutely ill patients. "When I think of a model of an Emergency Nurse, I think of a person that's high energy, that's got lots of stamina, who is quick on their feet, can think through things, and is confident themselves to be assertive when they have to be. They also have to be people that can be a team player".

One nurse in particular expressed the belief that this constant stimulation within the Department was what she perceived to be the most ideal environment for her as a nurse. "After you've done Emerg. at this hospital, what else in the world could possibly stimulate you?" It was her belief that once an individual had worked within this challenging, exciting, demanding environment, anyone leaving the Department to work elsewhere would be "bored at their new job within a week". Emergency nursing was perceived to be more challenging than the more basic routine aspects of working on a nursing unit.

> I like that I get to use my nursing skills that I've been trained to do. When you're working on a medical unit you'll hang some IV's, give some meds, you'll prepare them (patients) for some tests, you will change diapers, you will make beds, you will feed people. So out of an eight hour work day, two or three hours really requires what they (hospital) are paying me for.

This individual appeared to feel unchallenged by the experience of working on a unit, and needed to be a part of a patient care setting where there were greater demands

on her knowledge and skills, making her feel more worthwhile and professionally satisfied. The nurse's sense of satisfaction and personal achievement was closely associated with being able to effectively and efficiently meet the challenges of the Emergency Department as a member of the health care team.

The interviews with the nurses not only focused on the benefits of Emergency nursing but also facilitated discussions regarding frustrations and what the staff perceived to be some difficulties of working within such a setting. The nurses were concerned regarding the often "demanding" nature of their patients, the feeling of powerlessness and lack of respect, and at times, the frustration with the environment. "Our space has not increased and, of course, the bed situation has decreased. We can't send patients upstairs so they're waiting here. Definitely it affects the staff, it affects all of us I guess. You know we're like mice in a bowl, or rats in a bowl that we tend to eat each other sometimes because our environment is not terribly conducive".

Powerlessness was expressed as the lack of the ability to have control as to the types and numbers of patients coming into Emergency. This feeling by the staff was closely associated with concern about patient safety in view of the increasing volume of patients. The fear was that at some point as the nurses get busier and busier, something critical could get missed. "They're plugged up to the rafters with people, and they still keep coming in. Somebody may get missed. It gets dangerous. It gets frightening. I go home scared to death that I've missed something ...and I have missed things. Simply through the numbers, simply not being able to lay hands on people, not having the time to lay hands on people. Part of that's the nature of the beast in Emergency".

Caring for inpatients waiting in the Department for extended periods of time until a bed could be found for them was also placing increasing demands on the Emergency staff. Sometimes several pages of physician orders were left for the Emergency nurses to initiate as the patient waited for a bed. During situations where the patient flow would come to a

halt when the attention and focus of the nurses and physicians were appropriately meeting the needs of the critically ill, it was extremely difficult trying to quickly meet the needs of urgent patients. "It depends what the activity of the Department is. Now if the Department is very busy...and there's a lot of sick, sick patients there and you feel torn towards these patients that are coming (with a) pre-scheduled appointment versus the patients that really truly need you because they need the nursing care, they need your skills in order to perhaps make it through".

Very often, the patients would not express their anger or frustration with the physicians, but would direct their feelings towards the nursing staff. This would at times lead to verbal conflicts between the patients and the Emergency nurses when both individuals were frustrated with the situation. Since the emergent and urgently ill patients were sure to be seen first, it would be the nonurgent patients with whom the nurses and physicians would get irritated.

Occasionally the result of the frustration by both the staff and nonurgent patients would be formal complaints about the patients' treatment and/or staffs' behavior. Even though the number of formal complaints remain relatively few, one staff member noted that, compared to previous years, there was an increase. "They're (patient complaints) much more frequent than they were years ago...I don't believe that we got a lot of complaints (at that time), not the way we do now. I mean they're formal, they're phoned in, they're written, and yet, the percentage of complaints we get per the number of patients we see...it is very, very low, but they're doing it. So they're demanding for whatever reason that they're rights be looked after".

When the discussion on the need nonurgent patients felt to be seen by someone was removed from the Emergency setting and its related busyness, the physicians and nurses could identify that for some patients, Emergency may be their only alternative. It was believed by one staff member that a part of the problem was attitudinal, that

nonurgent patients must begin to be recognized as a part of the patient population who will continue to seek medical intervention through the Emergency Department. "So I think it's just their attitude towards those patients (nonurgent), 'cause we're here and they're around. We're going to see them and if we can't fight the attitude, there's just going to be more problems and more difficulties". Changing attitudes regarding abuse of the system by nonurgent patients, was perceived to be the responsibility of both the physician and nurses. "I think we have to work on attitudes, both as physicians and the nurses and I believe the physicians do set a significant proponent of the tone in the Department". This same physician eluded to the fact that frustration with the "system" resulted in not only potential conflict with patients, but also among the staff. "They're (nurses) tired of the anger, they're tired of being frustrated with the system, they're tired of being pushed around and asked to do the tenth thing when they've got nine people waiting for something else. And I don't blame the nurses a damn bit for being angry or getting fed up with it, or letting it out on me".

One of the Emergency nurses with less experience also expressed the concern that other staff members' frustration has unfavorably influenced her professional behavior or that of other staff nurses. She believed that for some long term Emergency nurses, their longevity on the unit under these types of circumstances may have made them "a little callous", and that it would probably be advantageous for them to look for a more suitable area to nurse. "If I start to act like them (callous nurses), I hope I will recognize that it's time to go do something different for a while".

During the discussions, the staff all emphasized the need to work as a team. The comradery of the staff was a critical component of the Emergency Department. One physician believed that facilitating a positive work environment was key in promoting a more healthy work setting which would result in ultimately more effective patient care. "The comradery between nurses and physicians has to be fostered and should be nurtured

to death". This individual also emphasized the need to establish a means for staff to release their stress and pent up emotions which are inherent in working in such a stressful area. "I think there needs to be adequate in-house systems for people debriefing, that are dealing with stress. Stress Management courses, whatever it takes because we haven't, I haven't been taught how to deal with stress".

The need for debriefing was seen as a means to establish more effective coping mechanisms for the staff. As one of the Emergency physicians had identified, both nurses and physicians need to establish some form of effective coping with all the tragedies and stresses of the Emergency Department. "And we as physicians don't really have an outlet either, so until we start dealing with it, people are just going to cope with it in whatever way they've always been accustomed to do. Sometimes it's with your peer that you're on duty with, and sometimes it's with your wife, sometimes it's with nobody". The lack of effective debriefing and being unable to "unload emotionally" was perceived to be the cause of staff becoming "hardened" and having more difficulty working effectively. In addition to the need for debriefing sessions was also the need for staff to gain insight into the type of patients with whom they have the most difficulty and to learn how to "react to the inner city patients, the alcoholics, and the drugs, and the nonurgent patients".

Caring for patients in Emergency was defined by the Emergency staff in several ways. For most staff caring was defined in terms of interventions for a problem, illness, or injury. One staff member qualified this by saying caring varied drastically based on the business of Emergency as well as the individual nurses and physicians. "It depends on the day. It depends on the circumstances. It depends on the nursing team. It depends on the physician and it's not consistent but probably the biggest difference is the patient load, I mean that really dictates it". All Emergency nurses and physicians interviewed believed that patients coming to the Emergency Department, received a very high quality of care. "They may not get complete care in that if they're busy we'll focus in on their problem that

they present with, but they get care and I think they get a bang for their buck when they come into our place. And as time permits, then there's a greater depth and people will go deeper and deeper into a problem, but I think generally speaking in the time I've been there, I think the patients get a pretty good deal at the (hospital name)". Caring was qualified as physical, diagnostic care. When discussed further, caring was addressed in terms of a personal focus.

A few of the Emergency nurses believed that some of the staff who didn't feel comfortable providing the humanistic element of caring, chose Emergency partly because they perceived that it was not a critical component of Emergency nursing. These nurses could be commended on their level of knowledge and technical ability in providing quick Emergency care to patients. "Staff that don't enjoy that component (humanistic caring) gravitate toward our Emergency and like it because they don't have to deal with it. There's no time to deal with a lot, but sort of good, all 'round nursing. Nurses that think that's an important aspect don't stay. We lose them out of our department". It seemed from the comments of the Emergency nurses, that the degree of humanistic caring provided to Emergency patients, was very much dependent on the individual nurse providing care. "We have lost some of the caring I think along the way that I believe was there (in the past). Now a lot of nurses tell me...there's still a percentage that give the good T.L.C. and care of the patient...this has changed. There is less of that going on. It's almost like a task-oriented thing now for a number of people, get them in ...and then leave them (patient) until the blood work comes back".

It was apparent that one of the greatest areas of discrepancy throughout the staff interviews was "what behaviors exhibit caring?". Based on the previous nurse's statement, caring was perceived as providing the "extras", such as blankets, tidying patients before they were discharged. As one nurse discussed, somehow a "gradual erosion of care" had taken place where these comfort measures now were not provided as a normal

expectation, as they had been in the years past. For this nurse the decrease in caring was exemplified by the lack of ensuring completeness of nursing care. "I think we are less caring to them (patients), and, I say "we" cause I know I have sent patients back (to the nurse caring for them) because they're not properly ready to go home, whether it be the dress or the way they look". For other staff, they admitted feeling as though the amount of humanistic caring provided to Emergency patients was decreasing drastically based on their observations that the Emergency staff were "not interacting" with patients.

The staff in general expressed the belief that the Emergency nurses have progressively become more task-oriented, particularly in the face of trying to cope with an ever-increasing workload. The nurses often feel they barely had enough time to cope with what the patient had come in with, and did not have time for any extra "baggage".

> I mean an Emergency Department is as I see it a very task-oriented job and nursing tends to be task-oriented to a large degree. Unless a patient is being admitted and is going to be in the department a long time, then I think you can start getting into some of these other things. But, I don't think you can get into the emotional and psychological components of every patient that comes in the department. You wouldn't have time".

The belief held by several of the nurses was that during busy times in Emergency, interacting with patients was the first to go. "There's time restraints. The emotional welfare and psychological welfare of the patient is probably the first to go". The time constraints and heavy workload on nursing was also felt by another nurse to be responsible for eliminating much of the humanistic caring of patients. "When something has to give, that's the part that gives (caring). I think we've been short staffed so long that people are forgetting that component and it's been forgotten and it's been lost". This nurse alluded with sadness to the fact that when there had been time to spend with patients, staff had seldom taken the opportunity to interact with the patients. Somehow over the last

few years, the concept of caring had been fragmented. No longer was it taken for granted that caring for a patient incorporated both physical and humanistic aspects.

For one nurse providing the extras for one patient and "getting a hug" when the patient was leaving the hospital, served to reinforce her belief that even though the day may be a busy one, spending a few extra moments with a patient was met with great appreciation. "I was busy that day too. Like I didn't think that I was to her, what she thought I was to her. I think I just chitty-chatted for the thirty seconds after you've taken her vits (vital signs) and get her story. If you can smile, or just relate to them (patients) some how". It was clear that the significance of the nurse's brief interaction had a lasting impact on this particular nurse which served to stay with her long after the patient left the Department.

A "good" Emergency nurse seemed to be characterized as a highly skilled individual who could assess the patient, prioritize the patients' needs and quickly perform the necessary tasks and complete the physicians orders. Only one of the staff included in their discussion of the qualities of the Emergency nurse, someone who was skilled at psychologically assisting patients during their crisis. The focus of the Emergency nurse was clearly skills and tasks.

> I think what has evolved over the last couple of years is a problem with both physicians and nursing, but you're (nursing) reacting to the medical needs and that's all you [redacted] the time for. You don't have time for the other sort of nursing, patient care, the psychological needs or the emotional needs of the patients. That's not provided anymore I don't think. I think there's certainly some nurses that are willing, their personality provides it and under certain circumstances they provide it but on the whole, I think generally because of the demand on the nurse to get the medical component done, they don't have time.

This behavior was also noted by another staff member who felt that while some of the "old timers" in Emergency would take the opportunity during quieter periods in the department to be there and talk with their patients, the majority of staff would not. The rationale for these actions was based on what this nurse believed to be a way of coping with the demanding fast-pace of Emergency. "So what happens when we get a quiet period, what do the nurses do? Instead of going to the bedside and talking to the patients, (there's some that do), there's some of the old-timers who are very good at that. They're doing some form of coping mechanism or debriefing or something". In these situations, this staff member believed that the overcrowded facilities and heavy workloads were in part the main basis for the movement away from providing humanistic care.

Part of the belief as to why nurses tend to avoid spending any additional time with patients was the concern that, if they stopped, the patients might ask them for something or request assistance. Since the nurses at times felt they could barely cope with the existing workload, they felt they could not afford to risk getting more to do.

> I had an incident report where a woman had peed in her bed and a nurse couldn't get to her. So the nurses stop looking at the patients. They walk down the hall with tunnel vision on the floor when they're there so they don't have to look at the patients. So that they don't have to have any contact with the patients because the patients are gonna ask them to do something. They don't have time to take care of them.

The frustration of the nurse while she was relating this situation was clearly apparent and seemed to leave her with a strong feeling of guilt in not being able to provide the level of care she wanted to deliver due to the workload.

As a means of survival or coping, the staff member focused on just keeping up with the bare minimum of what must be done to care for the patient. Sharing on a more personal level required more energy than the nurse or physician at times was capable of

expending. "If you're burned, you're burned. You can close the hole, you can also clean the wound, you can always dress the wound, but you can't always deal with the heart".

The lack of sufficient nursing staff to care effectively for Emergency patients was perceived to be the major source of the problem by one of the nurses.

> I need more people to care for those patients. Then the nurses won't be aggravated, the patients won't be aggravated, the doctors won't be aggravated, the inner city won't be aggravated, the people working on social service roles won't be aggravated and the people higher up will be happy because they won't have any complaints. This is the solution to the problem but nobody listens.

Clearly Emergency nurses saw the difficulties in providing effective care to the patients as purely a matter of inadequate numbers of staff to meet the demands of the Department. This same individual defined caring as both the technical and humanistic qualities of a "trained professional", and appeared to get great satisfaction from her patients when she was able to provide thorough care. "It's not that I went out there and said, 'Okay, I'm gonna care about you'. It's, 'Well, I'm a nurse, this is what I do. I'll help you sort out what the problem is, I know who you can go talk to'. You're a body of knowledge that walks around and you can help people sort out what they need to know, you sort out who they need to see. If they need their back rubbed, you're not afraid to touch them. You're not afraid to stand up for them".

The Emergency staff interviewed in this study, were extremely positive regarding their decision to work in Emergency. The fast paced, challenging environment provided satisfaction. The comradery and team work were seen an attractive asset and essential to the delivery of effective Emergency care. However, the reality of some of the frustrations within the area, at times, overshadowed the staff's enthusiasm regarding Emergency care.

The impact of the increase in nonurgent patients on the Emergency Department over the last several years has resulted in a heightened discrepancy between the staffs'

philosophy of Emergency nursing, care of the critically ill and trauma patient; and the reality of the changing utilization of Emergency Departments by nonurgent patients. The overcrowded facility and heavy staff workloads resulted in a more task-oriented approach to Emergency care. Although the Emergency staff were confident that the technical and/or diagnostic aspect of care provided to all patients was of high quality, there was an awareness that humanistic caring was either not being provided, or only seen as an "extra", when there was time. With the changing trend in utilization, a gradual erosion of humanistic caring in Emergency nursing appears to have occurred.

Emergency staff recognized that at times, Emergency may be the only alternative for nonurgent patients, however, nonurgent patients were generally perceived as adding unnecessary and inappropriate workload on the staff. The care of nonurgent patients did not provide the stimulation for the majority of staff, challenge their knowledge, nor require their advanced technical skills. The "demanding" nature of nonurgent patient, the feeling of powerlessness by the staff in controlling the types and numbers of Emergency patients, and the increased volume of patients, particularly nonurgent, resulted in frustration and occasionally verbal conflict. Since the legitimacy of nonurgent patients in the Emergency Department was most often in question, the staff felt the frustration was, at times, directed to this group of patients.

Chapter 5

Discussion of Findings

The study of the experience of the nonurgent patient in Emergency facilitated the development of a decision-making model. The model, used by nonurgent patients, identifies the process by which these individuals assessed their illness or health concern and chose the option to visit a specific Emergency Department. An explicit part of the model is the factors which are influential in determining the appropriate health care service. Validation of aspects of the decision-making model has been noted by Field (1982) who identified three phases of the care-seeking process: preactive, interactive, and postactive.

The assessment process of nonurgent patients was strongly influenced by past experiences. How long patients were prepared to wait prior to seeking health care was dependent upon patients' perception of their illness, the effectiveness of self-care methods, and the influence of significant others in the decision.

What needs to be emphasized is the sincere belief by nonurgent patients that they feel they have made an appropriate choice in coming to Emergency, and that they believe their illness warrants attention. Nonurgent visits have been labelled as "trivial" in the literature (Small & Seime, 1986). The perceptions of the Emergency staff also supported this belief, that for a large number of nonurgent patients, the decision to seek care in Emergency for minor, or seemingly trivial health concerns was viewed as inappropriate, based on poor judgement, and reflected an abuse of the health care system. Since almost 70 to 90% of all illnesses are managed without seeking assistance through the health care system (Zola, cited in Tripp-Reimer, 1984), it is apparent that the majority of illnesses experienced by individuals are managed successfully through alternative methods such as

self-care. When the individuals perceive that efforts to care for themselves have not been successful, selection of the appropriate health care service is initiated.

What became evident from the study was the lack of understanding and insight by the staff of patients' perceptions of illness. Staff in Emergency demonstrated a belief that the primary focus in Emergency was on the diagnosis and treatment of "disease", with little recognition of "illness". The concept of disease was based on the premise that an "abnormality of the structure of the body, organs, and system" (Demurs et al., 1980, p.1086) must be present. In the absence of a distinguishable disease, health care professionals have greater difficulty dealing with illness which is based on the "patient's" perception and definition of sickness" (Demurs et al., 1980, p.1086). When Emergency staff and patients' perceptions of disease and illness differ, the potential for conflict situations are increased (LaFargue, 1985). Such a distinction between disease and illness has also been identified as a potential cause of patient and family dissatisfaction, and result in noncompliance and ultimately inadequate care (Kleinman, 1978).

Patients coming to Emergency do so based on their perception of illness. To recognize and appreciate why the patient is seeking medical assistance, for what seems to be a trivial complaint, requires an understanding of the patients' perspective. It is apparent that when health care professionals focus on the diagnosis and treatment of disease, and the patients focus on illness, a dichotomy is present (Eisenberg, 1977). Critical information is absent in the assessment and management of nonurgent patients unless health care professionals seek to understand and utilize the concepts of both disease and illness. A model of health, which integrates both disease and illness, is reflected in Dunn's Model of Health (Dunn, cited in Tripp-Reimer, 1984, p.104). Through the use of such a model, a greater understanding of patients' perception of their illness can be incorporated into the assessment of patients. Such an understanding can facilitate improved communication, a stronger relationship between the patient and health care provider, a

plan of care that is based on a more thorough and accurate assessment of the patient, and ultimately improved patient outcomes (Kleinman, 1978). As noted by Cranwell (cited in Molde, 1986), patients often come to Emergency with hidden agendas. Once the patient expresses an initial concern, if the environment appears conducive, the patient may reveal a second or hidden concern for which they require care.

Information regarding the patient's perceptions of illness can be obtained through the use of Kleinman's Explanatory Model (Kleinman, 1981). This model assesses the patient's perceptions of illness, the self-care methods employed, and the patient's expectations of treatment. This information will not only facilitate a more thorough assessment of the patient's health concern, but also promote more appropriate treatment and subsequent satisfaction with care by both the health care professional and patient.

Nonurgent patients were criticized for their neglect in considering to seek health care through sources other than the Emergency Department. This was not the case for any of the nonurgent patients interviewed in the study. All the patients, verbalized a process whereby an assessment of the concern was completed and alternatives were evaluated, prior to the decision that the Emergency Department was the appropriate source of medical care. The selection of health care services was strongly influenced by both the knowledge of resources, as well as past experiences.

Although the majority of patients had an established family physician, they may or may not have attempted to contact the physician. Often the decision was based on the knowledge of factors limiting the availability of the physician, such as the time of day, day of the week, restricted office hours, and length of time to obtain an appointment. Based on previous experience, patients evaluated these factors, including their assessment of the health concern, and how long they felt they could wait. Patients expressed confidence in the family physician, and at times utilized the physician as a form of validation that they should seek medical care. Occasionally patients would also phone their physician to seek

direction and assistance in their selection of the appropriate source of medical care. For patients without an established physician, their selection of health care services was more limited.

The advent of Medi-Centres had originally been predicted in studies by Jacobs, Garrett, and Wersinger (1971) and Ferber (1983) to act as an attractive alternative for health care of nonurgent patients. This was not consistently apparent from the findings. Four of the nine nonurgent patients did not consider Medi-Centres to be a viable alternative, either as the result of past experiences, the perceived quality of care, or a lack of knowledge regarding the location of the nearest Medi-Centre. Since two of the patients were unclear as to what a Medi-Centre was, obviously these patients were even more limited in their selection of health care services. The patients who appeared to consider Medi-Centres, did so once they eliminated the possibility of seeing their own family physician. Patients who were not aware of what a Medi-Centre was resided in the inner city. Problems with a lack of knowledge, regarding the concept of Medi-Centres, transportation concerns, and funding issues when the individual was on Social Assistance acted as Jeterrents. The alternatives in seeking health care were therefore decreased to either a family physician or an Emergency Department. For these individuals with limited financial resources, the primary source of healthcare was the Emergency Department. The influence of socioeconomic factors in the decision-making process was apparent in the findings and is consistent with the literature (Wabschall, 1983; Gibson, 1973).

For hospitals such as the one under study, it is critical for staff to be aware of the community it serves. A community with lower socioeconomic status will generally have a high incidence of individuals who will continue to utilize the Emergency Department as their primary source of health care due to inadequate personal resources, or limited health care services within the community. In such areas where the availability of health care services are limited such as in inner city locations, the Emergency Department may be the

only source of health care. Greater insight should reflect a more accepting attitude of the staff in recognizing the role of the Emergency Department for this group of individuals. The display of dissatisfaction and frustration by users toward patients from the inner city may act as a deterrent to their seeking care. The only viable source of health care for such individuals may be eliminated as a result.

Nonurgent patients' perceptions of Emergency Departments are consistent with factors identified in the literature. The Emergency department was perceived to be the patient's "best choice" due to its convenience, 24 hour operation, ease of access, and availability of diagnostic tests and specialists. The majority of nonurgent patients in this study believed the Emergency Department to be their only and/or best alternative due to the unavailability of their family physician (Davidson, 1978), or due to the time of day, or day of the week. For these patients Emergency was seen as a "last resort" for obtaining medical care.

For some of the nonurgent patients, the decision to go to Emergency seemed to have been influenced by previous experiences when their family physician had arranged to see them in Emergency. Such experiences may serve to validate the utilization of Emergency Departments for minor illnesses in the future. Also evident from the study was the absence of any comments by the nonurgent patients of being referred at any time to a Medi-Centre by a family physician or by the staff in Emergency. Since the patients readily identified their confidence in their family physician and health care professionals, the lack of direction at any time to a Medi-Centre, may act as a negative influence in the patients consideration of Medi-Centres as a viable alternative to health care in the future.

The choice of hospital was strongly influenced by proximity, as was recognized by Davidson (1978) and Wabschall (1983). Once patients arrived at the decision to seek health care through an Emergency Department, they based their selection of the hospital on which facility was the closest and ultimately more convenient. For some of the patients

in this study, however, the strongest determining factor was where their family physician had admitting privileges, and where the patients' medical records could be accessed.

Past experience of receiving care in a facility was very important in influencing the decision as to which hospital to choose. The type of care provided and the experience with the staff affected the patient's decision and may ultimately be more important than convenience or proximity, as in the case of the Native patient who felt she was treated extremely poorly by the nurses and would go to "any other hospital" as a result. The reputation of the hospital also influenced the selection an Emergency department. Since reputation of a facility is affected by comments of previous patients, a negative experience by one patient in an Emergency Department may reflect the loss of several potential patients in the future. The influence of significant others in the decision to seek medical care was identified by Suchman (cited in McKinlay, 1973), who noted that 75% of the individuals in their study discussed their illness with a relative before seeking assistance. It is apparent that the relatives and significant others could therefore influence the decision of the patient based on past experiences with seeking care. The importance of hospitals to concentrate their efforts on patient satisfaction, or "customer service" (Gagnon, 1991), may lie in the recent changes of hospital funding, which incorporates the volume of patients into the funding equation.

Patients' expectations of care were closely associated with the evaluation of the quality of care. Insight into the expectations of nonurgent patients by health care professionals is essential in working collaboratively towards providing quality clinical care. It is difficult for most patients to evaluate the quality of care provided for them. To a great extent, quality is determined by a perception of caring, compassion, and respect (Spitzer, 1988; Strasen, 1988; Steiber, 1988). The basis for establishing such a relationship between the patient and health care professional is effective communication (Strasen, 1988). Although patient satisfaction does not necessarily reflect quality of care

(Eriksen, 1987), patients correlate quality with concern and caring by health care professionals (Strasen, 1988; Steiber 1988). Since all health care facilities and health care professionals are concerned about the quality of care delivered to patients, awareness into how patients perceive quality is essential.

An expectation frequently expressed by nonurgent patients in the Emergency Department was humanistic caring which was demonstrated through listening, empathic concern, reassurance, and respect. Only through efforts to incorporate a greater emphasis on humanistic caring can nurses demonstrate empathy and caring towards patients and influence patient satisfaction.

Emergency nurses are credited primarily for advanced technical skill and clinical competence (Morrison, 1989). Of interest was the nonurgent patients' perceptions of the role of the Emergency nurse. One patient expressed the belief that the nurse had no impact on her care; the other nonurgent patients described the role as technical, taking vital signs, and assisting in preparing the patient for examination by the physician. The role of the Emergency nurse was not perceived to be critical to the care of the patient, however, when a behavior of the nurse was seen as extremely negative or positive, this directly influenced the level of satisfaction of care.

Since Emergency nurses spend the greatest majority of time caring for patients in the Emergency Department, it is apparent that the actions of the nurses are the most influential on the evaluation by the patients of their care. Without effectively communicating a sincere concern for patients and assessing the patients' expectations of their care, efforts to promote patient satisfaction will fail. Though concerns expressed by nonurgent patients may appear "trivial" to Emergency staff, patients seeking care in an Emergency Department experience anxiety and a feeling of abandonment (Gagnon, 1991). As demonstrated by Rempusheski et al. (1988) in a study of letters from patients and families concerning their experience in hospital, "when service needs are not met,

perceptions of even the most competent, caring nurse behavior may be dampened accordingly" (p. 47).

Patient satisfaction is an important aspect of quality of care. Whereas most of the Emergency staff interviewed defined caring as medical support, humanistic caring was often seen as an "extra" only provided "when there was time". Although caring attitudes are identified within the National Emergency Nurses' Affiliation Standards of Emergency Nursing Practice, and are seen as essential elements in professional behavior to promote the establishment of a helping relationship (National Emergency Nurses' Affiliation, 1986), Emergency staff closely associated "caring" with competence. From the nonurgent patients' perspective, competence was assured when the patients sought care in the Emergency Department. What patients perceived as caring, and what was extremely important to them, was the psychological comfort through respect, reassurance and concern for the individual. Comments by nonurgent patients that exemplified the effect of "caring behaviors" by the Emergency staff were closely associated with the feeling that they had received "good service". Such behaviors as assisting a patient out of her car, spending a little time talking with the patient, giving them a warm blanket, or a smile as the nurse walked down the hallway, made a difference to the patients. Absence of these elements from the patient's care will result in decreased satisfaction which has been shown to ultimately influence compliance with treatment and future decisions in seeking health care (Larsen & Rootman, 1976; Fox & Storms, 1981; MacKeigan & Larson, 1989).

Nonurgent patients felt that often the legitimacy of the severity of illness as well as their visit to Emergency was questioned by the staff. The Emergency nurses confirmed the doubt as to the legitimacy of nonurgent patients coming to the Emergency Department for care, believing that the decision by the nonurgent patient to come to Emergency reflected extremely poor assessment skills of the patient, laziness in terms of seeking the most "convenient" source, overexaggeration of the illness, and abuse of the health care

system. Since the Emergency nurse at the main desk of Emergency is the first person to assess the patient and will subsequently discuss the initial impressions of the patient to both the nursing and medical staff, labelling and inappropriate judgements may directly influence all subsequent providers of care. It is apparent that the perceptions of the nurses, therefore, have a great impact on when and how the patient is treated. Such quick "moral evaluations" (Roth, 1972) by the staff without attempting to gain an understanding of the patient's perception of illness, can negatively influence the patient's diagnosis, treatment, and management.

Although the possibility of labelling and judging patients may occur with any patient who seeks care in Emergency, the nonurgent patients are most vulnerable to this behavior by the staff since they generally come to Emergency with more minor, vague concerns. Forming preconceived notions about nonurgent patients incorporated the issues of labelling and legitimacy. All staff recognized that nonurgent patients were at times labelled as unmotivated in seeking other health care sources, abusing the health care system, or "leaching off the system". Some nonurgent patients interviewed in this study, expressed concern as to how they felt "judged" by the staff, based on their reason for admission, their behavior, or their dress. Patients who had utilized the services of the Emergency Department in the past, admitted to occasionally exaggerating their illness and ensuring that they "looked ill enough" for the nurse at the desk to prevent feeling as though they should not have come to Emergency. The nurses, on the other hand, expressed a firm belief that nonurgent patients should not come to an Emergency Department. Unless no other source of health care was available to the patient, such as during the night, most Emergency staff perceived the nonurgent patient as "abusing" the health care system.

The role of the Emergency Department was believed by the staff to be for the care of acute and critically ill patients. Since nonurgent patients do not comply with the

perceptions of the staff, they are therefore not perceived as "legitimate" Emergency patients. It is questionable as to how the quality of care provided to the nonurgent patients is affected by the staffs' belief that the patient is not rightfully an Emergency patient. This impression by the staff is largely influenced by the busyness of the department, and the behavior of the patient. Since the nonurgent patients are appropriately seen last when acute or critical patients are in the department, often the nonurgent patients feel uninformed and "left" waiting. At times the staff expressed a need to show the nonurgent patients that coming to Emergency was not necessarily the fastest so as to influence future selection of health care sources. This would be most evident when the nonurgent patient expressed concern over the length of time they had to wait to be seen by a physician. The result of such doubt of the legitimacy of the patient may be reflected as a lack of worth towards the patient, and may directly influence the nurse-patient relationship (Grief, 1993), as well as the quality of the nonurgent patient's care (Roth, 1972).

Emergency nurses expressed a feeling of powerlessness. These feelings reflected a lack of control over the type and volume of patients who sought care in the Emergency Department. In particular, nonurgent patients were seen as adding extra unnecessary work to an already heavy workload. The nonurgent patients in the study readily accepted the prioritization of patient care, however, they needed to feel that they were valued as a patient, and that their assessment of their illness was recognized and believed by the Emergency staff. A major frustration of the patients was lack of information. They often did not feel informed as to why they were waiting, or that they were being cared for as they waited (Gagnon, 1991). If the patient was waiting in the examination room, it was important for the patient occasionally to see a nurse and be asked if there was anything that the patient required as they waited. Patients felt that being informed as they waited

made them more comfortable and ultimately more satisfied with their care. When they felt ignored and avoided by the staff, the result was often frustration and occasionally, anger.

The staff's perception of Emergency nursing focused on the challenges of the fast-paced, highly technical environment. It was apparent that all the Emergency nurses in the study were committed to providing a high standard of care for the patients in the Department. Part of the difficulty in the acceptance of nonurgent patients is based on the nurses' philosophy regarding Emergency nursing: the care of acutely and critically ill patients. Strategies to incorporate the care of the nonurgent patient into the Emergency philosophy are critical to improve the quality of care.

A Fast track method of care responds to the needs of consumers and the Emergency staff (Hodges, 1990; Fadale, 1990; Covington, Erwin, & Sellers, 1992; DiGiacomo & Hatzipetro, 1992). For nonurgent patients, the convenience and expedience of being seen in a separate area in the Emergency Department committed towards the care of nonurgent conditions, has been shown to be both innovative and cost-efficient (Covington, Erwin, & Sellers, 1992). The advantage of implementing a fast track process of caring for nonurgent patients, also significantly decreases the stress on the Emergency staff, by not mixing the nonurgent patients with the acute and critically ill patients. Since a specific staff member is assigned to the fast track area, the remaining Emergency staff do not feel as though they are pressured to take time away from caring for critical patients to care for individuals with nonurgent conditions. Through the establishment of a specific program for the nonurgent patient, the hospitals recognized the need and demonstrated the value and appropriateness of the selection of the Emergency Department by nonurgent patients. The staff members subsequently are influenced into accepting the legitimacy of nonurgent Emergency visits, are more satisfied, and, therefore, relate to the nonurgent patient in a more accepting and caring manner. The benefits of a fast track program also

extends to increased satisfaction with the quality of care by the nonurgent patient (DiGiacomo & Hatzipetro, 1992).

The findings from this study showed a difference in how Emergency staff and nonurgent patients defined caring. Emergency nurses need to focus on the technical component of providing care, as well as on the humanistic qualities of caring. The standard of Emergency care must also require a greater emphasis on the necessity of humanistic caring in providing quality nursing care. A method to decrease the task-oriented nature of Emergency nursing may be through the implementation of primary nursing as a model for the delivery of care (Blair, Spanger, Walts, & Thompson, 1982). A high degree of professional satisfaction has been identified when primary nursing was introduced into selected Emergency Departments (Blair, Spanger, Walts, & Thompson, 1982; Tucker, 1986). Primary nursing could also promote the development of a closer relationship between the Emergency nurse and the nonurgent patient, which could also positively influence patient satisfaction.

Greater emphasis on caring and establishing an effective interpersonal relationship with patients will directly influence the level of satisfaction and quality of care provided in the Emergency Department. Since the nurses expressed frustration with nonurgent patients and guilt in feeling as though they were not able to provide a high standard of nursing care at times, establishing a closer relationship with the patients in Emergency and being positively rewarded for providing a more humanistic approach to care, may result in greater personal and professional satisfaction.

In order to effectively care for others, time must also be devoted to caring for the Emergency staff and assisting and/or teaching them to cope with the various stressful situations encountered in Emergency (Burns, 1983; Keller, 1990). The establishment of a debriefing program would be an asset to promote the health and longevity of the employee, and the quality of care delivered to patients. Such a program would also be

useful in teaching Emergency staff various methods of dealing with their own frustrations and focus on increasing the effectiveness of the staffs' communication skills.

Education of the staff concerning the decision-making model of nonurgent patients in seeking care, the use of assessment tools such as Kleinman's Explanatory Model (1981) to gain insight into nonurgent patients' perceptions of illness, and educational tools to assist in patient teaching for nonurgent patients (Clarke, 1982), are important to facilitate greater insight by Emergency nurses and assist them in caring for nonurgent patients.

The loss of control and powerlessness expressed by the Emergency nurses may be influenced through the implementation of changes in the delivery of care to nonurgent patients. Responding to the changes in utilization and developing creative methods of strategies to provide a high standard of care to all Emergency patients is critical to the professional growth and development of Emergency nursing. The social and moral obligation of nursing incorporates the nurse's commitment towards meeting the needs of patients (Larson, 1986). Consumers of health care have the right to choose what they see as the appropriate source of health care (AARN, 1991). In order to continue to strive to maintain the provision of quality care, adapting to change is critical. "The future will belong to those who prepare for it" (Andreoli & Musser, 1985, p.20).

Implications

The clinical significance and applicability of this study facilitates the development of more effective strategies to care for nonurgent patients in the Emergency Department. The findings of this study have implications which extend to all areas of nursing practice: clinical, education, administration, and research. Implications in each of these areas will be addressed.

Clinical

1. Establishing an effective relationship between the Emergency nurse and patient is based primarily on effective communication. Effective communication techniques can assist the Emergency nurse in reflecting a caring, compassionate, and respectful attitude towards patients, each of which has been closely correlated with patients' perceptions of "quality" of care. Efforts should be taken to further develop the communication skills of Emergency staff to facilitate such a rapport between the Emergency nurses and patients.

2. Emergency staff are extremely conscientious and committed to providing a high standard of technical, diagnostic care, but this alone is not perceived as "caring" by patients. Humanistic caring, identified as listening, empathy, reassurance, and respect, is an essential component of Emergency nursing. The standard of Emergency care must incorporate both technical, and humanistic care.

3. The Emergency Department has a significant role in providing medical care to all individuals, particularly those with a lower socioeconomic status. Greater insight should reflect a more accepting attitude of the staff in recognizing the role of the Emergency Department for this group of individuals. Recognition of the culture of the inner city itself, by the Emergency nurses, as well as of the community served by the individual hospital, is essential in facilitating further insight into the needs of the community by Emergency staff.

4. To effectively care for others, energy must be devoted to assisting the Emergency staff, and/or teaching them methods of coping with stressful situations encountered in Emergency. To ensure the health of Emergency nurses, methods of dealing with stressors within the environment should be considered, such as debriefing.

Education

1. Education of Emergency staff concerning the decision-making model of nonurgent patients in seeking sources of health care, use of assessment tools such as Kleinman's Explanatory model, and patient educational tools to assist in the patient teaching of nonurgent patients will facilitate greater insight by the nurses working in Emergency and assist them in delivering optimum care to nonurgent patients.

2. Education of the existing staff and changes to the orientation program for Emergency staff should incorporate information regarding the nonurgent patient and their perceptions of illness, how patients perceive quality of care, and the role of the Emergency nurse according to the Emergency Standards of Nursing Practice.

Administration

Government

1. Appropriate utilization of health care services is essential to the effective management of limited fiscal resources. Since the selection of health care services is influenced strongly by availability and access to resources, it is therefore recommended that both provincial and federal government administrations assess the availability of health care services within communities to facilitate more effective utilization.

Hospital

1. The communities served by hospitals are very individual. In order to promote quality of care, an assessment of the community, as well as the demographic profile of the nonurgent patient, is critical. Since the sources for health care are extremely limited for patients residing within the inner city, hospitals situated in these areas must see the

Emergency Department as serving their "communities", and staff working in the facility must integrate this belief into their practice.

2. Efforts by hospital administrators to facilitate patient satisfaction with care must become more of a conscious concern of health care institutions to ultimately ensure adequate funding. All aspects of patient care which influence patients' perceptions of quality and ultimately, satisfaction, are critical in affecting the reputation of the hospital and in patients' decisions as to which hospital to choose. Ensuring a heightened awareness by all hospital staff, particularly those working in Emergency of behaviors such as moral judgements and labelling of patients which directly affects the quality of care provided to patients is vital.

3. Although sources of health care, such as Medi-Centres have been established to meet the needs of nonurgent patients, it is apparent that nonurgent patients will continue to utilize Emergency Departments as an alternative. Emergency Departments should respond to the needs of nonurgent patients through the implementation of a "fast track" process of providing care.

4. The implementation of an alternative care delivery model in Emergency, such as primary care, has been shown to promote the establishment of a closer relationship with patients in Emergency, positively influence patient satisfaction, and increase the professional and personal satisfaction of Emergency nurses.

Research

1. To promote the development of knowledge, the application and evaluation of the decision-making model in similar, as well as a variety of settings would further validate the model and its use. Therefore, replication of this study is recommended.

2. Since the characteristics of Emergency room populations are individual, research to determine the demographic profile of patients coming to specific Emergency Departments needs to be conducted.

3. Research to evaluate the effect of a change in delivery of care in the Emergency department, such as a Fast Track method of care, should be initiated to ascertain the effect on both the quality of patient care, as well as, job satisfaction.

4. To gain greater insight and knowledge of patients' perceptions of caring behaviors by Emergency nurses, research to examine this concept would be extremely beneficial.

5. To assist nonurgent patients in their selection of health care alternatives, an educational program should be developed and evaluated.

6. Since the care of the nonurgent patient may be provided through various health care sources, a broader review of the Health Care Delivery System, which includes services both internal and external to the hospital should be evaluated to assess possible difficulties of access.

7. To further promote improved quality of patient care for all categories of patients coming to Emergency Departments, further research to investigate the experiences of urgent and emergent patients is recommended.

8. Since family members and/or significant others have been shown to influence patients selection of health care services as well as patients' perceptions of care received in Emergency, research should be conducted on families of patients coming to Emergency. This will not only assist Emergency nurses in caring for such families in the Department but will also provide further insight regarding how families and significant others perceive the quality of nursing care.

Reflections On Research Methods

Examination of the research methods upon completion of this study, identified some areas for consideration in future research. Although the risk of elite bias was reduced through the careful selection of informants, in hospitals with similar community characteristics, such as a large multicultural component, it would be beneficial, given adequate resources, to translate written materials in major languages and provide translators. This would facilitate the inclusion of additional ethnic groups. I do believe that the inclusion of these groups of individuals would provide further depth and completeness to the investigation of nonurgent patients in a particular setting.

Participant mortality is an important consideration when undertaking a research study in Emergency Departments. Due to the often transient nature of many patients it is often difficult to arrange secondary interviews due to an inability to locate patients. In this study secondary interviews were unable to be conducted due to the sudden relocation of two informants. A possible method of decreasing participant mortality may be through initial contact with the informant within twenty-four hours following their visit to Emergency. At this time an appointment would be established for a second interview within a week. I experienced some difficulty arranging interviews if it was done at a later date.

Several factors in the research methods utilized in this study facilitated added reliability and validity of the results. The large amount of data to be analyzed promoted greater depth of analysis. Frequent validation of the data with informants and my thesis supervisor facilitated the validity of the results, as well as, the reliability of the decision trail. Previous clinical experience and knowledge regarding Emergency nursing was an asset in understanding the culture of the clinical setting and in the purp ful selection of informants.

REFERENCE LIST

REFERENCE LIST

Aamodt, A.M. (1982). Examining ethnography for nurse researchers. Western Journal of Nursing Research, 4(2), 209-221.

Alberta Association of Registered Nurses (1991). Response to the Barer-Stoddart report: Toward integrated medical resource policies for Canada, i-v.

Andren, K.G., & Rosenqvist, U. (1987). Heavy users of an emergency department: A two year follow-up study. Social Science and Medicine, 25(7), 825-831.

Andreoli, K.G., & Musser, L.A. (1985). Challenges confronting the future of emergency nursing. Journal of Emergency Nursing, 11, 16-21.

Anson, O., Carmel, S., & Levin, M. (1991). Gender differences in the utilization of emergency department services. Women and Health, 17(2), 91-104.

Artinian, B.A. (1988). Qualitative modes of inquiry. Western Journal of Nursing Research, 10(2), 138-149.

Berman, J.I., & Luck, E. (1971). Patients ethnic backgrounds affect utilization. Hospitals, 45, 64-68.

Blair, F., Sparger, G., Walts, L., & Thompson, J. (1982). Primary nursing in the emergency department: Nurse and patient satisfaction. Journal of Emergency Nursing, 8, 182-186.

Bogdan, R.C., and Biklen, S.K. (1982). Qualitative research for education: An introduction to theory and methods. Toronto: Allyn & Bacon.

Burns, H.K., Kirilloff, L.H., & Close, J.M. (1983). Sources of stress and satisfaction in emergency nursing. Journal of Emergency Nursing, 9, 329-336.

Burns, N. (1989). Standards for qualitative research. Nursing Science Quarterly, 2(1), 44-52.

Carter, S., & Mowad, L. (1988). Is nursing ready for consumerism? Nursing Administration Quarterly, Spring, 74-78.

Chinn, P. (Ed.). (1986). Nursing research methodology. Baltimore: Aspen.

Clarke, K. (1982). Patient health teaching needs....nonurgent emergency department patients. Journal of Emergency Nursing, 8, 298-303.

Corbin, J. (1986). Qualitative data analysis for grounded theory. In W. Chenitz & J. Swanson (Eds.). From practice to grounded theory (pp. 91-101). Menlo Park, CA: Addison-Wesley.

Covington, C., Erwin, T., & Sellers, F. (1992). Implementation of a nurse practitioner-staffed fast track. Journal of Emergency Nursing, 18, 124-131.

Crichton, A., Hsu, D., & Tsang, S. (1990). Canada's health care system: Its funding and organization. Ottawa: Canadian Hospital Association Press.

Davidson, S.M. (1978). Understanding the growth of emergency department utilization. Medical Care, 16(2), 122-132.

Demurs, R.Y., Altmore, R., Mustin, H., Kleinman, A., & Leonardi, D. (1980). An exploration of the dimensions of illness behavior. Journal of Family Practice, 11(7), 1085-1092.

Derlet, R.W., & Nishio, D.A. (1990). Refusing care to patients who present to an Emergency department. Annals of Emergency Medicine, 19(3), 262-267.

DiGiacomo, E., & Hatzipetro, D. (1992). Emergency department fast tracking. Outreach, 5, 5.

Eisenberg, L. (1977). Disease and illness: Distinctions between professional and popular ideas of sickness. Culture, Medicine and Psychiatry, 1, 9-23.

Eriksen, L.R. (1987). Patient satisfaction: An indicator of nursing care quality? Nursing Management, 18(1), 31-35.

Fadale, J. (1990). Overcrowding -- comfort, consideration, convenience. Journal of Emergency Nursing, 16, 132-133.

Ferber, M.S. (1983). Impact of freestanding emergency centers on hospital emergency department use. Annals of Emergency Medicine, 12(7), 35-39.

Fetterman, D.M. (1989). Ethnography: Step by step. London: Sage.

Field, P.A. (1982). Client care-seeking behaviors in a community setting and their sources of satisfaction with nursing care. Nursing Papers, 14(1), 15-28.

Field, P.A. (1989). Doing fieldwork in your own culture. In J. Morse (Ed.). Qualitative nursing research: A contemporary dialogue (pp.79-91). Rockville, MD: Aspen.

Field P.A., & Morse, J.M. (1985). Nursing research: The application of qualitative approaches. Rockville, MD: Aspen.

Fox, J., & Storms, D. (1981). A different approach to sociodemographic predictors of satisfaction with health care. Social Science and Medicine, 15A, 557-564.

Gagnon, L. (1991). Customer service: Is the answer better communication? Journal of Emergency Nursing, 17, 63-64.

Gibson, G. (1973). EMS: A fact of ambulatory care. Hospitals, 47, 59-64.

Glaser, B., & Strauss, A. (1966). Qualitative modes of enquiry. Western Journal of Nursing Research, 10(2), 138-148.

Good, B.J. (1977). The heart of what's the matter: The semantics of illness in Iran. Culture, Medicine and Psychiatry, 1, 25-58.

Government of Alberta. (1989). An agenda for action: Report of the advisory committee on the utilization of medical services.

Grief, C.L. (1993). Nurses' evaluation of patient characteristics in an emergency setting. Unpublished masters thesis. University of Alberta, Edmonton.

Hammersley, M., & Atkinson, P. (1983). Ethnography: Principles in practice. London: Tavistock.

Hedges, J.R., Singal, B.M., Rousseau, E.W., Sanders, A.B., Bernstein, E., McNamera, R.M., & Hogan, T.M. (1992). Geriatric patient emergency visits part 11: Perceptions of visits by geriatric and younger patients. Annals of Emergency Medicine, 21(7), 57-61.

Hodges, S.R. (1990). Ambulatory track: On the right track. Dimensions, 67(4), 21-23.

Jacobs, A.R., Garrett, J.W., & Wersinger, R. (1971). Emergency department utilization in an urban community. Journal of the American Medical Association, 216(2), 307-312.

Jacoby, L., & Jones, S. (1982). Factors associated with emergency department use by 'repeater' and 'nonrepeater' patients. Journal of Emergency Nursing, 8, 243-257.

Jones, S., Jones, P., & Meisner, B. (1978). Identification of patients in need of psychiatric intervention. Medical Care, 16(5), 372-382.

Jones, S.L., Ring, S., Jones, P.K., & Katz, J. (1985). Emergency department use in relation to health care experiences and behavior. Journal of Emergency Nursing, 11, 145-148.

Keller, K.L. (1990). The management of stress and prevention of burnout. Journal of Emergency Nursing, 16(2), 90-95.

Kinney, T.J., & Gerson, L. (1983). Utilization of a free-standing emergency center by patients with and without private physicians. Annals of Emergency Medicine, 12(12), 762-764.

Kirkpatrick, J.R., & Taubenhaus, L.J. (1967). The nonurgent patient on the emergency floor. Medical Care, 5(1), 19-24.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness and care: Clinical lessons from anthropological and cross-cultural research. Annals of Internal Medicine, 88, 251-258.

Kleinman, A. (1981). On illness meanings and clinical interpretation: Not 'rational man', but a rational approach to man the sufferer/man the healer. Culture, Medicine and Psychiatry, 5, 373-377.

Kleinman, A. (1988). The illness narratives: Suffering, healing, and the human condition. New York: Basic Books.

Kluge, D.N., Wegryn, R.L., & Lemley, B.R. (1965). The expanding emergency department. Journal of the American Medical Association, 191(10), 97-101.

Knafl, K.A., & Webster, D.C. (1988). Managing and analyzing qualitative data: A description of tasks, techniques and materials. Western Journal of Nursing Research, 10, 195-218.

LaFargue, J. (1985). Mediating between two views of illness. Topics in Clinical Nursing. October, 70-76.

Larson, D., & Rootman, I. (1976). Physician role performance and patient satisfaction. Social Science and Medicine, 10, 29-32.

Larson, L.L. (1986). Toward a more ethical emergency nursing practice. Journal of Emergency Nursing, 12, 1-2.

Lavenhar, M.A., Ratner, R.S., & Weinerman, E.R. (1968). Social class and medical care: Indices of nonurgency in use of hospital emergency services. Medical Care, 6, 368-380.

Lee, S.S., Solon, J.A., & Sheps, C.G. (1960). How new patterns of medical care affect the emergency unit. The Modern Hospital, 94(5), 97-101.

Leininger, M.M. (Ed.). (1985). Qualitative research methods in nursing. Toronto: Grune & Stratton.

Lewis, B.R., & Bradbury,Y. (1982). The role of the nursing profession in hospital accident and emergency departments. Journal of Advanced Nursing, 7, 211-221.

MacKeigan, L.D., & Larson, L.N. (1989). Development and validation of an instrument to measure patient satisfaction with pharmacy services. Medical Care, 27(5), 522-536.

McKinlay, J.B. (1973). Social networks, lay consultation and help-seeking behavior. Social Forces, 51, 275-292.

Mechanic, D. (1986). The concept of illness behavior: Culture, situation and personal predisposition. Psychological Medicine, 16, 1-7.

Molde, S. (1986). Understanding patients' agendas. Image: Journal of Nursing Scholarship, 18, 145-147.

Morrison, P. (1989). Nursing and caring: A personal construct theory study of some nurses' self-perceptions. Journal of Advanced Nursing, 14, 421-426.

Morse, J. (1986). Quantitative and qualitative research: Issues in sampling. In P. Chinn (Ed.). Nursing research methodology (pp. 181-193). Baltimore: Aspen.

Morse, J.M. (1989). Qualitative nursing research: A contemporary dialogue. Rockville, MD: Aspen.

Morse, J.M. (Ed.). (1989). Qualitative nursing research. London: Sage.

Morse, J.M. (Ed.). (1991). (2nd Ed.). Qualitative nursing research. London: Sage.

National Emergency Nurses Affiliation. (1986). Standards of Emergency Nursing Practice. Canada.

Parker, S. (1982). Life change in emergency department patients with nonacute conditions. Journal of Emergency Nursing, 8, 34-37.

Perkoff, G.T., & Anderson, M. (1970). Relationship between demographic characteristics, patient's chief complaint, and medical care destination in an emergency room. Medical Care, 8, 309-323.

Powers, M.J., Reichelt, P.A., & Jalowiec, A. (1983). Use of the emergency department by patients with nonurgent conditions. Journal of Emergency Nursing, 9, 145-149.

Rempusheski, V., Chamberlain, S., Picard, H., Ruzanski, J., & Collier, M. (1988). Expected and received care: Patient perceptions. Nursing Administration Quarterly, 12(3), 42-50.

Robertson, M.H.B., & Boyle, J.S. (1984). Ethnography: Contributions to nursing research. Journal of Advanced Nursing, 9, 43-49.

Roth, J.A. (1971). Utilization of the hospital emergency department. Journal of Health and Social Behavior, 12, 312-320.

Roth, J.A. (1972). Some contingencies of the moral evaluation and control of the clientele: The case of the hospital emergency service. American Journal of Sociology, 77, 839-856.

Roth, J.A. (1972). Staff and client control strategies in urban hospital emergency services. Urban Life and Culture, April, 39-61.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Saunders, A.B. (1992). Care of the elderly in emergency departments: Where do we stand? Annals of Emergency Medicine, 21(7), 41-43.

Siler-Wells, G.L. (1988). Directing Change and Changing Direction. Ottawa: Canadian Public Health Association.

Small, K.G., & Seime, R.J. (1986). The use of education to reduce utilization of emergency health care services: A case illustration. Journal of Behavior Therapy and Experimental Psychiatry, 17(1), 43-46.

Snell, F.I., Jones, S., & Yoder, L. (1987). Factors in choosing an urgent care center versus an emergency department. Journal of Emergency Nursing, 13, 355-358.

Solon, J.A. & Riss, R.D. (1972). Patterns of medical care among users of hospital emergency units. Medical Care, 10(1), 60-72.

Spitzer, R. (1988). Meeting consumer expectations. Nursing Administration Quarterly, Spring, 31-38.

Spradley, J. (1979). The ethnographic interview. Toronto: Holt, Rinehart & Winston.

Steiber, S.R. (1988). Social issues: How consumers perceive health care quality. Hospitals, 5, 84.

Strasen, L. (1988). Executive development: Incorporating patient satisfaction standards into quality of care measures. Journal of Nursing Administration, 18(11), 5-6.

Stratmann, W.C., & Ullman, R. (1975). A study of consumer attitudes about health care: The role of the emergency room. Medical Care, 13, 1033-043.

Strauss. A. (1987). Qualitative analysis for social scientists. Cambridge: Cambridge University.

Toohey, S.J. (1984). Parent-nurse interactions in the emergency department: An exploratory study. Unpublished masters thesis. University of Alberta, Edmonton.

Torrens, P.R., & Yedvab, D.G. (1970). Variations among emergency room populations: A comparison of four hospitals in New York city. Medical Care, 8(1), 60-75.

Tripp-Reimer, T. (1984). Reconceptualizing the construction of health: Integrating emic and etic perspectives. Research in Nursing and Health, 7, 101-109.

Truman, C. (1993). Use of the emergency department by the nonurgent pediatric patient. Unpublished masters thesis. University of Alberta, Edmonton.

Tucker, F. (1986). Implementation of primary nursing in one emergency department. Journal of Emergency Nursing, 12, 157-162.

VanMaanen, J. (1988). Tales of the field: On writing ethnography. Chicago: University of Chicago Press.

Vaughan, H.F., & Gamester, C.E. (1966). Why patients use hospital emergency departments. Hospitals, 40, 59-62.

Wabschall, J.M. (1983). Why parents use the emergency department for nonemergency infant care. Journal of Emergency Nursing, 9, 37-40.

Walker, L.L. (1975). The emergency department as the entry point into the health care system. Hospital Topics, 2, 46-47.

Worth, C., & Hurst, K. (1989). Accident and emergency: False alarm? Nursing Times, 85(15), 24-27.

Yoder, L., & Jones, S. (1981). Changing emergency department use: Nurses' perceptions and attitudes. Journal of Emergency Nursing, 7, 156-161.

APPENDIX A

PATIENT INFORMATION LETTER

Patient Information Letter

_____,1992

Dear Emergency Patient,

I am a nurse who is conducting a nursing research study to look at what it is like being a patient in an Emergency department. For many years I have worked in an Emergency department and have become very interested in learning more about how patients feel about their visit to Emergency. I do not work in this Emergency department.

If you would like to take part in this research project, two or more interviews will be conducted with me, as the researcher. Our first interview will take place as you want, either prior to being seen by a Doctor, after you have been seen in Emergency, or one to two days after your visit to Emergency. A second interview will take place in about two weeks, at a time and place which is best for you. Each interview will last about one hour.

During these interviews, we will talk about what it was like for you, being a patient in Emergency. You are free to refuse to answer any question that I ask. Each interview will be taped. Only myself, the typist, and a member of my research committee will listen to the tapes. No one will know your name except me. All information will be confidential.

There is no risk to you if you decide to take part in the study. There will be no difference in the care you get should you agree or not agree to take part. There will not be any delay in your care should you decide to take part in this study. You will be free to withdraw from the study at any time and all the information you have already given to me can be taken out of the research project if you wish. There may not be any direct benefits

to you for taking part in this study. It is hoped that any knowledge gained may help nurses better understand the experience, resulting in better care for patients in Emergency.

If you feel you would like to take part in this study and would like more information, please let the Unit Clerk at the Emergency desk know and he or she will contact me.

Thank you for your interest.

Yours sincerely,

Carla Policicchio, R.N.

Master of Nursing Candidate.

APPENDIX B

FAMILY/FRIENDS OF PATIENT

RESEARCH INFORMATION LETTER

Family/Friends of Patient

Research Information Letter

_____,1992.

Dear Sir/Madame:

I am a nurse who is conducting a nursing research study to look at what it is like being a patient in an Emergency department. For many years I have worked in an Emergency Department and have become very interested in learning more about how patients feel about their experience of coming to Emergency. I do not work in this Emergency department.

If you would like to take part in this research project, one or more interviews will be conducted with me, as the researcher. Interviews will be held at a time best for you. During the interviews, some questions will be asked about your experience in the Emergency department and that of your family member or friend who was being treated in Emergency. You are free to refuse to answer any questions that I ask. Each interview will be taped. Only myself, the typist, and a member of my research committee will listen to the tapes. No one will know your name except me. All information will be confidential.

There is no risk to you if you decide to take part in the study. You will be free to withdraw from the study at any time and all the information you have already given to me can be taken out of the research project if you wish. The care of your family member or friend will not be affected in any way should you decide not to take part in this study. There may not be any direct benefits to you for taking part in this study. It is hoped that

any knowledge gained may help nurses better understand the experience, resulting in better care for patients in Emergency.

I will come back in a little while to ask if you are interested in talking more about the study with me.

Thank you for your interest. I look forward to hearing from you.

Yours sincerely,

Carla Policicchio, R.N.

Master of Nursing Candidate.

_____Yes, I am interested in this study and I would like more information. Please fill out the following form.

Name_____

Address_____

_____

_____

Phone_____

APPENDIX C

URGENT PATIENT INFORMATION LETTER

Patient Information Letter

_____,1992.

Dear Emergency Patient,

I am a nurse who is conducting a nursing research study to look at what it is like being a patient in an Emergency department. For many years I have worked in an Emergency department and have become very interested in learning more about how patients feel about their visit to Emergency. I do not work in this Emergency department.

If you would like to take part in this research project, two or more interviews will be conducted with me, as the researcher. Our first interview will take place as you want, either prior to being seen by a Doctor, after you have been seen in Emergency, or one to two days after your visit to Emergency. A second interview will take place in about two weeks, at a time and place which is best for you. Each interview will last about one hour.

During these interviews, we will talk about what it was like for you, being a patient in Emergency. You are free to refuse to answer any question that I ask. Each interview will be taped. Only myself, the typist, and a member of my research committee will listen to the tapes. No one will know your name except me. All information will be confidential.

There is no risk to you if you decide to take part in the study. There will be no difference in the care you get should you agree or not agree to take part. There will not be any delay in your care should you decide to take part in this study. You will be free to withdraw from the study at any time and all the information you have already given to me can be taken out of the research project if you wish. There may not be any direct benefits

to you for taking part in this study. It is hoped that any knowledge gained may help nurses better understand the experience, resulting in better care for patients in Emergency.

If you feel you would like to take part in this study and would like more information, please let the Unit Clerk at the Emergency desk know and he or she will contact me.

Thank you for your interest.

Yours sincerely,

Carla Policicchio, R.N.

Master of Nursing Candidate.

APPENDIX D

EMERGENCY DEPARTMENT STAFF

RESEARCH INFORMATION LETTER

Emergency Department Staff

Research Information Letter

Research Title: The Nonurgent Patient in the Emergency Department

Dear Emergency Department Staff,

I am a nurse who is conducting a nursing research study to look at what it is like being a nonurgent patient in an Emergency Department. For many years I have worked in an Emergency Department and have become very interested in learning more about what the experience is like. I do not currently work in this Emergency department.

If you agree to take part in this research project, one or more interviews will be conducted with me, as the researcher. Interviews will be scheduled at a time best for you.

During the interviews, some questions will be asked about your experience with nonurgent patients in the Emergency Department. You are free to refuse to answer any questions that I ask. Each interview will be taped. Only myself, the typist, and a member of my research committee will listen to the tapes. No one will know your name except me. All information will be confidential.

There is no risk to you if you decide to take part in the study. You will be free to withdraw from the study at any time and all the information you have already given to me can be taken out of the research project if you wish. There may not be any direct benefits to you for taking part in this study. It is hoped that any knowledge gained may help

Emergency staff better understand the experience of nonurgent patients, resulting in even better care for patients in Emergency.

If you are interested in being part of this study or would like more information, I may be contacted at the following number: 434-5119. If I am not available to answer your call, please leave a message and I will contact you in the near future.

Thank you for your interest. I look forward to hearing from you.

Yours sincerely,

Carla Policicchio, R.N.

Master of Nursing Candidate

_____Yes, I am interested in this study and I would like more information. Please fill out the following form:

Name:_____

Address:_____

_____

_____

Phone:_____

APPENDIX E

INFORMANT DEMOGRAPHIC DATA FORM

Code #____

INFORMANT DEMOGRAPHIC DATA FORM

1. Age: _____
2. Gender: _____
3. Highest level of education: _____
4. Ethnic background: _____
5. Marital status: _____
6. Employment status: _____

APPENDIX F

NONURGENT PATIENT CONSENT FORM

NONURGENT PATIENT CONSENT FORM

Research Title: The Nonurgent Patient in the Emergency Department

Researcher
Carla Policicchio, R.N., BScN.
Master of Nursing Candidate
Faculty of Nursing
University of Alberta
Phone: 434-5119

Supervisor
Dr. Marion Allen
Professor
Faculty of Nursing
University of Alberta
Phone: 492-6411

The purpose of this research project is to find out what it is like to be a patient in the Emergency Department when you do not have life-threatening injuries.

If you want to take part in this study, two or more interviews will be held with the researcher. Interviews, lasting about 60 - 90 minutes, will take place at the hospital, or at a time and place of your choice. During the interviews, you will be asked to talk about your experience in the Emergency department. If you do not want to, you do not have to answer any question. Each interview will be taped and then typed. Only the researcher, the typist, and a member of my research committee will listen to the tapes. Your name will not be on any typed notes. You will only be identified by a number. Only the researcher will know which number is yours. At the end of the study your name, address and phone number will be destroyed. All consent forms will be destroyed at the end of the study. All information will be confidential. The tapes and typed notes will be kept under lock and key.

Comments made by you may be used in talks or articles about the study. Your name will not be used at any time.

There is no risk to you if you decide to take part in the study. There will not be any delay in being seen by a Doctor if you have decided to take part in the research. You will be free to drop out of the study at any time and all the information you have already given may be taken out of the research project if you wish. Your care will not be different should you decide not to continue. There may not be any direct benefits to you for taking part in this study. It is hoped that any knowledge gained may help nurses better understand the experience, resulting in better care for patients in Emergency.

I, _____have read this information and want to be in the study called 'The Nonurgent Patient in The Emergency Department'. I have had the chance to ask questions about the study and my part in it. The researcher, Carla Policicchio, has answered all my questions at this time. I have been given a copy of this consent form.

Participant _____ Date _____

Researcher _____ Date _____

Witness _____ Date _____

If you would like a summary of this study, please sign below:

Name _____

Address _____

_____

_____

APPENDIX G

FAMILY/FRIENDS CONSENT FORM

FAMILY/FRIENDS CONSENT FORM

Research Title: The Nonurgent Patient in the Emergency Department

Researcher
Carla Policicchio, R.N., BScN.
Master of Nursing Candidate
Faculty of Nursing
University of Alberta
Phone: 434-5119

Supervisor
Dr. Marion Allen
Professor
Faculty of Nursing
University of Alberta
Phone: 492-6411

The purpose of this research project is to find out what it is like for people to be a patient in the Emergency Department when you do not have a life-threatening illness.

If you agree to take part in this study, two or more interviews will be held with the researcher. Interviews, lasting about 60 to 90 minutes, will take place at the hospital, or at a time and place of your choice. During the interviews, you will be asked to talk about your experience in coming with a patient to the Emergency department. If you do not want to, you do not have to answer any question. Each interview will be taped and then typed. Only the researcher, the typist, and a member of my research committee will listen to the tapes. Your name will be known only to the researcher and will be erased from the tape and not typed. Your name will not be on any typed notes. You will only be identified by a number. Only the researcher will know which number is yours. At the end of the study your name, address and phone number will be destroyed. All consent forms will be destroyed at the end of the study. All information will be confidential. The tapes and typed notes will be kept under lock and key.

Comments made by you may be used in talks or articles about the study. Your name will not be used at any time.

There is no risk to you if you decide to take part in the study. The care of the person you come to the Emergency department with will not change in any way. You will be free to drop out of the study at any time and all the information you have already given may be taken out of the research project if you wish. There may not be any direct benefits to you for taking part in this study. It is hoped that any knowledge gained may help nurses better understand the experience, resulting in better care for patients in Emergency.

I,_____have read this information and agree to be in the study called 'The Nonurgent Patient in The Emergency Department'. I have had the chance to ask questions about the study and my part in it. The researcher, Carla Policicchio, has answered all my questions at this time. I have been given a copy of this consent form.

Participant _____ Date _____

Researcher _____ Date _____

Witness _____ Date _____

If you would like a summary of this study, please sign below:

Name: _____

Address _____

_____

_____

APPENDIX H

URGENT PATIENT CONSENT FORM

Urgent Patient Consent Form

Research Title: The Nonurgent Patient in the Emergency Department

Researcher
Carla Policicchio, R.N., BScN.
Master of Nursing Candidate
Faculty of Nursing
University of Alberta
Phone: 434-5119

Supervisor
Dr. Marion Allen
Professor
Faculty of Nursing
University of Alberta
Phone: 492-6411

The purpose of this research project is to find out what it is like to be a patient in the Emergency Department when you do not have a life-threatening illness.

If you want to take part in this study, two or more interviews will be held with the researcher. Interviews, lasting about 60 to 90 minutes, will take place at the hospital, or at a time and place of your choice. During the interviews, you will be asked to talk about your experience in the Emergency Department. If you do not want to, you do not have to answer any question. Each interview will be taped and then typed. Only the researcher, the typist, and a member of my research committee will listen to the tapes. Your name will be known only to the researcher and will be erased from the tape and not typed. Your name will not be on any typed notes. You will only be identified by a number. Only the researcher will know which number is yours. At the end of the study your name, address and phone number will be destroyed. All consent forms will be destroyed at the end of the study. All information will be confidential. The tapes and typed notes will be kept under lock and key.

Comments made by you may be used in talks or articles about the study. Your name will not be used at any time.

There is no risk to you if you decide to take part in the study. There will not be any delay in being seen by a Doctor if you have decided to take part in the research. You will be free to drop out of the study at any time and all the information you have already given may be taken out of the research project if you wish. Your care will not be different should you decide not to continue. There may not be any direct benefits to you for taking part in this study. It is hoped that any knowledge gained may help nurses better understand the experience, resulting in better care for patients in Emergency.

I,_____have read this information and agree to be in the study called 'The Nonurgent Patient in The Emergency Department'. I have had a chance to ask questions about the study and my part in it. The researcher, Carla Policicchio, has answered all my questions at this time. I have been given a copy of this consent form.

Participant_____ Date_____

Researcher_____ Date_____

Witness_____ Date_____

If you would like a summary of this study, please sign below.

Name_____

Address_____

_____

_____

APPENDIX I

EMERGENCY DEPARTMENT STAFF CONSENT FORM

Emergency Department Staff Consent Form

Research Title: The Nonurgent Patient in the Emergency Department

Researcher
Carla Policicchio,R.N., BScN.
Master of Nursing Candidate
Faculty of Nursing
University of Alberta
Phone: 434-5119

Supervisor
Dr. Marion Allen
Professor
Faculty of Nursing
University of Alberta
Phone: 492-6411

The purpose of this research project is to find out what it is like to be a patient in the Emergency Department when you do not have a life-threatening illness.

If you agree to take part in this study, two or more interviews will be held with the researcher. Interviews, lasting about 60 to 90 minutes, will take place at the hospital, or at a time and place of your choice. During the interviews, you will be asked to talk about your experience in working with nonurgent patients in the Emergency Department. If you do not want to, you do not have to answer any question. Each interview will be taped and then typed. Only the researcher, the typist, and a member of my research committee will listen to the tapes. Your name will be known only to the researcher and will be erased from the tape and not typed. Your name will not be on any typed notes. You will only be identified by a number. Only the researcher will know which number is yours. At the end of the study your name, address and phone number will be destroyed. All consent forms will be destroyed at the end of the study. All information will be confidential. The tapes and typed notes will be kept under lock and key.

Comments made by you may be used in talks or articles about the study. Your name will not be used at any time.

There is no risk to you if you decide to take part in the study. You will be free to drop out of the study at any time and all the information you have already given may be taken out of the research project if you wish. There may not be any direct benefits to you for taking part in this study. It is hoped that any knowledge gained may help Emergency department staff better understand the experience, resulting in better care for patients in Emergency.

I,_____have read this information and agree to be in the study called 'the Nonurgent Patient in The Emergency Department'. I have had the chance to ask questions about the study and my part in it. The researcher, Carla Policicchio, has answered all my questions at this time. I have been given a copy of this consent form.

Participant_____Date_____

Researcher_____Date_____

If you would like a summary of this study, please sign below.

Name_____

Address_____

_____

_____